Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 26, 2020	2020_769646_0010	010556-20	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

IVY LAM (646)

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): Onsite on: May 28, 29, 30, 31; June 1, 2, 4, 8, 9, 10, 11, 15, 16, 17, 18, 19, 22, and 23, 2020; Offsite on: June 3, 5, and 24, 2020.

The following intake was completed during this CIS inspection:
Log # 010556-20 (CIS #2586-000016-20) related to alleged verbal and emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Director of Care (DOC), Registered Nurses (RN), Agency RNs, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency PSWs, Employee Engagement Specialist, Education Coordinator, Unit Clerk, Social Worker, and residents.

During the course of this inspection, the inspector reviewed resident and home records, relevant policies and procedures, and conducted observations, including staff-resident interactions and resident care provision.

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

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was promoted.

This inspection was initiated related to a Critical Incident System (CIS) report related to concerns raised by an agency Registered Nurse (RN). In the report, the RN made allegations of abuse against an identified Registered Practical Nurse (RPN), stating that multiple residents in the home voiced to the RN that they were afraid of the RPN. Review of the home's amended CIS report showed that the home's investigation was completed, and the RPN was no longer employed by the home.

Review of the home's investigation notes showed that during the agency RN's employment in the home, multiple residents had relayed to the RN that they were afraid of the RPN. These included resident #020, who voiced out to the agency RN multiple times concerning their fear of the RPN; and residents #021 and #022, who had expressed to the agency RN their dislike towards the RPN due to the RPN's attitude and how they spoke to the resident. According to the RN, they interpreted the residents' comments at times to be fear of the RPN and at other times as frustration towards the RPN.

Interview with the agency RN stated that they began working on the resident's unit on an identified date, and their last shift in the home was about one month after they started. The RN stated that during their employment in the home, resident #020 had told the RN they were afraid of the RPN but did not explain why they were afraid. The agency RN could not recall the first time that the resident had reported concerns to them, but stated it was throughout their employment in the home.

Review of the home's investigation notes into the incident showed that resident #020 stated that the RPN was condescending and offensive, and that the staff made them feel afraid because they threatened to send the resident to the hospital if they had more falls, and that the resident was afraid of going to the hospital. The resident also stated they did not want to go to the hospital because they did not want to become infected with an identified virus.

During interview with resident #020, they stated that the RPN had scared them and told them if they fell off their assistive mobility device one more time, they would send them to

the hospital.

Review of resident #020's care plan showed the resident required an identified assistive device and needed an identified level of assistance for locomotion.

During interview with the RPN, they stated that resident #020 would come out of their room on multiple occasions on their own without their identified assistive device, and the RPN had told the resident if they continued to fall, they would have to go to the hospital. The RPN stated that they had also asked the resident if they wanted to go to the hospital because they were ambulating without their assistive mobility device. The RPN further stated resident #020 had said they did not want to go to the hospital. They reminded the resident that the resident did not like hospitals and if the resident continues to ambulate without their identified mobility device, they will end up in the hospital. The RPN stated they did not mean what they said as a threat to the resident, but what they meant by their statements was a statement of facts; if a resident who needed an assistive mobility device was ambulating without one, they would fall and would end up in the hospital.

During interview with resident #021, one of the other residents who was mentioned by the RN to have voiced concerns regarding the RPN, they stated that they did not have issues with the RPN, and that the RPN had not made them afraid.

Interview with two other RPNs who worked regularly on residents #020, #021, and #022's floor, stated that they were not aware of any residents who had concerns regarding the alleged RPN, and that they did not have any concern about the RPN's behaviours or interactions with residents.

During interview with the acting Director of Care (DOC), they stated that the alleged RPN should consider the residents' perception of their words and actions and that the home had also previously addressed concerns of residents' rights with the RPN.

Interview with the Executive Director (ED) stated that the alleged RPN's employment with the home was terminated after this incident. [s. 3. (1) 1.]

2. Resident #022 was among the residents whom the agency RN stated had voiced concerns regarding negative interactions with the RPN.

Review of resident #022's progress notes during a two-month period, did not show any documentation regarding complaints and concerns about staff.

Review of the home's investigation notes showed that during the agency RN's employment in the home, multiple residents had relayed to the RN that they were afraid of an identified RPN. This included resident #020, who voiced out to the agency RN multiple times concerning their fear of the RPN. This also included resident #022, who had expressed to the agency RN their dislike towards the RPN's attitude and how they spoke to the resident. According to the agency RN, they interpreted the resident's comment as fear towards the RPN, and at other times, as frustration towards the RPN.

In an interview, the RN stated that resident #022 stated they did not get along with the RPN, but the resident did not relay any specific incidents to the RN.

Interview with resident #022 stated that the RPN was uncaring, disrespectful, and had no remorse for what they said. When asked to clarify, resident #022 stated that the RPN would call them by an identified name, which was not their preferred name. Furthermore, per resident, the RPN continued to call them by that identified name instead of their preferred name whenever they wanted the resident's attention, even though they would not respond when the RPN called them by that identified name. The resident stated the RPN's actions made them feel disrespected, and the RPN did not have good manners. The resident stated they had also heard the RPN call co-residents, "Hey you!" And that none of the residents liked the RPN.

The resident stated that they had not mentioned the RPN's actions to any staff members but had informed their own family member multiple times to address this with the home, but was not sure who their family member had informed.

During the interview with the alleged RPN, they had requested to end the interview and did not address questions regarding their interactions with resident #022.

Separate interviews with two RPNs who worked regularly on residents #020, #021, and #022's floor, stated that they were not aware of any residents who had concerns regarding the RPN. They also did not have any concern about the RPN's behaviours or interactions with residents.

During interview with the acting DOC, they stated that the RPN should consider the residents' perception of their words and actions and that the home had also previously

addressed concerns of residents' rights with the RPN.

Interview with the ED stated that the RPN's employment with the home was terminated after this incident. [s. 3. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

This inspection was initiated related to a CIS report related to concerns raised by an agency RN. In the report, the RN made allegations of abuse against an identified RPN, stating that multiple residents in the home voiced to the RN that they were afraid of the RPN. Review of the home's amended CIS report showed that the home's investigation

was completed, and the RPN was no longer employed by the home.

Review of the home's investigation notes showed that during the agency RN's employment in the home, multiple residents had relayed to the RN that they were afraid of the RPN. These included resident #020, who voiced out to the agency RN multiple times concerning their fear of the RPN; and residents #021 and #022, who had expressed to the agency RN their dislike towards the RPN due to the RPN's attitude and how they spoke to the resident. According to the RN, they interpreted the residents' comments at times to be fear of the RPN and at other times as frustration towards the RPN.

Interview with the agency RN stated that they began working on the resident's unit on an identified date. The agency RN could not recall the first time that the residents had reported concerns to them, but stated it was throughout their employment in the home. They stated that resident #020 had told them they were afraid of the RPN but did not explain why. Resident #022 had told the agency RN that their family member had previously reported their concerns to the home, but did not tell the agency RN of any specifics or incidents with the RPN. The agency RN stated that they considered what the residents said about the RPN as verbal and emotional abuse.

The agency RN further stated that because they had not received orientation and abuse training in the home when they started or during their time working in the home, they were not sure what to do, and went to report it to the Canadian Armed Forces (CAF) staff. The RN stated they had also notified another RPN of their concerns with the alleged RPN, where both staff members and residents appeared to be afraid of the RPN. The agency RN stated they had further concerns around an identified time period, and finally reported their concerns to the acting DOC in an electronic mail (e-mail) later that month; they still had not received abuse training from the home at this point. Review of the agency RN's e-mail to the acting DOC showed it was dated 12 days after the RN had suspected abuse from the RPN towards the residents.

Interview with the RPN who the agency RN had spoken with stated that they had worked regularly with residents #020, #021, and #022, but none of these residents had voiced any concerns to them regarding the alleged RPN. None of the residents had told the RPN that they were afraid of the alleged RPN. The RPN further stated that the agency RN had asked them if something was wrong with the alleged RPN. The RPN stated they told the agency RN not to worry, but if they had concerns, there are managers in the

home, and they can speak with them. The RPN stated that the agency RN never came back to them with any further concerns. The RPN stated they had worked regularly in the home.

Interview with another RPN, who worked regularly with the alleged RPN, stated that residents #020, #021, and #022, had not voiced any concerns about the alleged RPN. They stated that none of the residents had voiced concerns about the alleged RPN. The RPN further stated the agency RN had not mentioned any concerns regarding the alleged RPN to them.

During interview with a PSW, they stated that the alleged RPN was a very knowledgeable nurse and knew residents well, and the PSW did not have any concerns with them.

In an interview with the acting DOC, they stated that they were not aware of the agency RN's concerns regarding residents being afraid of the RPN until the agency RN wrote them an e-mail on an identified date, about 12 days after the RN began to have suspicion of verbal and emotional abuse from the RPN towards residents.

During interview with the ED, they stated that they were not aware of the agency RN's concerns regarding residents' being afraid of the RPN until about 12 days after it was suspected.

In an interview with the acting DOC, they acknowledged that the agency RN had suspected verbal and emotional abuse from the alleged RPN towards multiple residents and had reported this to the CAF staff and fellow registered staff. However, the RN had not reported this to management until about 12 days later, and the suspicion of alleged abuse of multiple residents was not immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: 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, to be implemented voluntarily.

Issued on this 9th day of September, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646)
Inspection No. / No de l'inspection :	2020_769646_0010
Log No. / No de registre :	010556-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020
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 :	Gale Coburn

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 3. (1).

Specifically, the licensee shall ensure that:
1) Residents #020, #022, and all residents are treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity.

2) All new staff and agency staff, hired in the home since April 1, 2020, receive training on:
a) The Residents' Bill of Rights,
b) The long-term care home's policy to promote zero tolerance of abuse and neglect of residents, and
c) The duty under section 24 of the Long-Term Care Homes Act, 2007 to make mandatory reports.

3) A record of the training provided for staff is kept and includes the dates the training(s) were held, and names and positions of staff who attended the training.

Grounds / Motifs :

1. The licensee has failed to ensure that residents' right to be treated with

courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was promoted.

This inspection was initiated related to a Critical Incident System (CIS) report related to concerns raised by an agency Registered Nurse (RN). In the report, the RN made allegations of abuse against an identified Registered Practical Nurse (RPN), stating that multiple residents in the home voiced to the RN that they were afraid of the RPN. Review of the home's amended CIS report showed that the home's investigation was completed, and the RPN was no longer employed by the home.

Review of the home's investigation notes showed that during the agency RN's employment in the home, multiple residents had relayed to the RN that they were afraid of the RPN. These included resident #020, who voiced out to the agency RN multiple times concerning their fear of the RPN; and residents #021 and #022, who had expressed to the agency RN their dislike towards the RPN due to the RPN's attitude and how they spoke to the resident. According to the RN, they interpreted the residents' comments at times to be fear of the RPN and at other times as frustration towards the RPN.

Interview with the agency RN stated that they began working on the resident's unit on an identified date, and their last shift in the home was about one month after they started. The RN stated that during their employment in the home, resident #020 had told the RN they were afraid of the RPN but did not explain why they were afraid. The agency RN could not recall the first time that the resident had reported concerns to them, but stated it was throughout their employment in the home.

Review of the home's investigation notes into the incident showed that resident #020 stated that the RPN was condescending and offensive, and that the staff made them feel afraid because they threatened to send the resident to the hospital if they had more falls, and that the resident was afraid of going to the hospital. The resident also stated they did not want to go to the hospital because they did not want to become infected with an identified virus.

During interview with resident #020, they stated that the RPN had scared them and told them if they fell off their assistive mobility device one more time, they

would send them to the hospital.

Review of resident #020's care plan showed the resident required an identified assistive device and needed an identified level of assistance for locomotion.

During interview with the RPN, they stated that resident #020 would come out of their room on multiple occasions on their own without their identified assistive device, and the RPN had told the resident if they continued to fall, they would have to go to the hospital. The RPN stated that they had also asked the resident if they wanted to go to the hospital because they were ambulating without their assistive mobility device. The RPN further stated resident #020 had said they did not want to go to the hospital. They reminded the resident that the resident did not like hospitals and if the resident continues to ambulate without their identified mobility device, they will end up in the hospital. The RPN stated they did not mean what they said as a threat to the resident, but what they meant by their statements was a statement of facts; if a resident who needed an assistive mobility device was ambulating without one, they would fall and would end up in the hospital.

During interview with resident #021, one of the other residents who was mentioned by the RN to have voiced concerns regarding the RPN, they stated that they did not have issues with the RPN, and that the RPN had not made them afraid.

Interview with two other RPNs who worked regularly on residents #020, #021, and #022's floor, stated that they were not aware of any residents who had concerns regarding the alleged RPN, and that they did not have any concern about the RPN's behaviours or interactions with residents.

During interview with the acting Director of Care (DOC), they stated that the alleged RPN should consider the residents' perception of their words and actions and that the home had also previously addressed concerns of residents' rights with the RPN.

Interview with the Executive Director (ED) stated that the alleged RPN's employment with the home was terminated after this incident. (646)

2. Resident #022 was among the residents whom the agency RN stated had voiced concerns regarding negative interactions with the RPN.

Review of resident #022's progress notes during a two-month period, did not show any documentation regarding complaints and concerns about staff.

Review of the home's investigation notes showed that during the agency RN's employment in the home, multiple residents had relayed to the RN that they were afraid of an identified RPN. This included resident #020, who voiced out to the agency RN multiple times concerning their fear of the RPN. This also included resident #022, who had expressed to the agency RN their dislike towards the RPN's attitude and how they spoke to the resident. According to the agency RN, they interpreted the resident's comment as fear towards the RPN, and at other times, as frustration towards the RPN.

In an interview, the RN stated that resident #022 stated they did not get along with the RPN, but the resident did not relay any specific incidents to the RN.

Interview with resident #022 stated that the RPN was uncaring, disrespectful, and had no remorse for what they said. When asked to clarify, resident #022 stated that the RPN would call them by an identified name, which was not their preferred name. Furthermore, per resident, the RPN continued to call them by that identified name instead of their preferred name whenever they wanted the resident's attention, even though they would not respond when the RPN called them by that identified name. The resident stated the RPN's actions made them feel disrespected, and the RPN did not have good manners. The resident stated they had also heard the RPN call co-residents, "Hey you!" And that none of the residents liked the RPN.

The resident stated that they had not mentioned the RPN's actions to any staff members but had informed their own family member multiple times to address this with the home, but was not sure who their family member had informed.

During the interview with the alleged RPN, they had requested to end the interview and did not address questions regarding their interactions with resident #022.

Separate interviews with two RPNs who worked regularly on residents #020, #021, and #022's floor, stated that they were not aware of any residents who had concerns regarding the RPN. They also did not have any concern about the RPN's behaviours or interactions with residents.

During interview with the acting DOC, they stated that the RPN should consider the residents' perception of their words and actions and that the home had also previously addressed concerns of residents' rights with the RPN.

Interview with the ED stated that the RPN's employment with the home was terminated after this incident.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to residents #003 and #004. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Voluntary Plan of Action (VPC) issued under s. 3. (1) 11. iv. on February 26, 2018 (2018_493652_0002), and
- Written Notice (WN) issued under s. 3. (1) 16. on July 2, 2020 (2020_754764_0006). (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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