Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie 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
Jan 18, 2019	2018_723606_0025	022870-17, 023044-17, 023553-17, 026428-17, 006992-18, 007252-18	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodhall Park Care Community
10260 Kennedy Road North BRAMPTON ON L6Z 4N7

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

JANET GROUX (606), ZINNIA SHARMA (696)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 4, 5, 6, 10, 11, 12, 14, 17, 18, 19, 20, and 21, 2018.

The following intakes were inspected:
Log # 022870-17 and # 023044-17 regarding staff to resident abuse and neglect;
Log # 026428-17 and # 023553-17 regarding resident to resident physical abuse;
Log # 007252-18 regarding transferring and positioning, personal support services; and
Log # 006992-18 regarding care concerns related to staffing shortages, resident responsive behaviours, resident supplies, and misinformation to the Ministry of Health and Long-Term Care (MOHLTC).

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Therapy Aides (RTA), Resident Relations Coordinator (RRC), Staffing Coordinator (SC), Peel Regional Police Department, Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed relevant documents including but not limited to, clinical records, assessment records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
5 VPC(s)
2 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. 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 not neglected by the licensee or staff.

A complaint and a Critical Incident (CI) \ were submitted to the Ministry of Health and Long-Term Care (MOHLTC) and reported an allegation of resident neglect.

The CI reported that staff alleged that resident #003 was not provided care on identified dates and that the resident told the home that they did not feel comfortable receiving care from PSW #133.

PSW #105 stated that resident #003 told them on an identified date that PSW #133 had taken away an activity they liked to engage in and provided care that was not chosen by the resident. The resident revealed that PSW #133 had provided care in an inappropriate manner and would not speak to them while they gave care. Two days later, PSW #105 stated resident #003 told them again that they were not given a choice to their care and that PSW observed an identified care was not provided due to the resident's appearance.

The home's staff schedule stated that PSWs #133, #106, and #122 were assigned to work together with resident #003. The home's investigation notes revealed three PSWs did not provide care resident #003 at an identified date and time.

The Administrator stated that the home completed an investigation and concluded that resident #003 had not received care at some time during the three days and was not provided the assistance they required.

The licensee has failed to ensure that resident #003 was not neglected by staff. [s. 19.

(1)]

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

A complaint submitted to the MOHLTC reported resident #006 was abused by resident #004 resulting in a serious injury.

Resident #004's progress notes stated that the resident unexpectedly pushed resident #006 while both residents were walking by each other resulting in resident #006 to fall.

PSWs #118 and #120, and RPN #130 stated that resident #004 was identified to display physical aggression that was at times unprovoked.They acknowledged that resident #004 pushed resident #006 to the floor.

The licensee has failed to ensure that resident #006 was protected from physical abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions.

A complaint and a CI report received by the MOHLTC reported a resident to resident altercation resulting in a serious injury.

Resident #004's progress notes stated that staff witnessed resident #004 pushed resident #006 resulting in resident #006 to fall.

Resident #004's progress notes were reviewed for an identified time period and revealed the resident had ongoing responsive behaviours towards staff and residents on a daily basis and at times displayed these behaviours unprovoked. The progress notes stated several incidents where resident #004 had an altercation with another resident and staff.

Resident #004's care plan identified the resident with displaying responsive behaviours towards staff and directed several interventions to manage the resident's behaviours. The care plan did not provide further steps to address how to prevent and/or minimize resident #004 from getting into further altercations.

PSWs #118 and #120 stated that resident #004 was known to display responsive behaviours towards staff and residents despite the interventions in place. They stated that they witnessed resident #004 push resident #006. RPN #130 stated that resident #004 was known have display responsive behaviours towards others and stated that resident #004 pushed resident #006.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint submitted to the MOHLTC reported concerns of staff shortage that has affected resident care.

Review of the home's daily schedule for an identified time period revealed the home scheduled Registered Nurses (RN) from identified nursing agencies on identified dates and shifts.

The Administrator and the Staffing Coordinator (SC) acknowledged that the home had used RNs from the agency when they were not able to schedule their own RN staff to work.

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

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the home's Prevention of Abuse and Neglect of a Resident policy was complied with.

A CI reported an allegation of staff to resident neglect involving resident #003.

The home's policy entitled, "Prevention of Abuse and Neglect of a Resident", stated that all employees are required to immediately report any suspected incident of neglect to the Director of MOHLTC and the Executive Director or designate in charge of the home.
A CI submitted to the MOHLTC reported an allegation of resident abuse and neglect.

PSW #105 stated that resident #003 informed them that a staff had provided them inappropriate care on identified dates but did not report the resident's concerns. They stated that they told PSW #134 two days after the resident shared their concerns with them and that it was PSW #134 who reported to the home.

The licensee has failed to ensure that the home's Prevention of Abuse and Neglect of a Resident policy was complied with.

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 home's Prevention of Abuse and Neglect of a Resident policy # VII-G-10.00 is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

1. A complaint submitted to the MOHLTC reported concerns regarding staffing issues and resident care concerns.

The progress notes stated that Recreational Therapy Aide (RTA) had assisted the resident out of their bed and transferred them to their wheelchair by themself.

Resident #010's care plan required two staff to provide extensive assistance via sit to stand lift to transfer the resident.

RTA #136 stated the resident requested to join in the recreational program that afternoon and that they had transferred the resident on their own. They acknowledged that they should have checked the resident's care plan for the correct transfer need and did not.

The Administrator and the Resident Relations Coordinator (RRC) acknowledged that RTA #136 did not transfer resident #010 safely.

2. A CI report indicated resident #001 had concerns regarding how they were transferred by staff.

Resident #001 stated that PSW #102 had positioned them in a particular way while the resident was in bed and did not call for assistance.

Resident #001's progress notes indicated that they continually complained of pain to an identified area of their body after the incident and evidence of an injury.

PSWs #100 and #101 stated that a technique was used to ensure safe transferring and positioning to prevent causing injuries or skin integrity impairment to a resident.

The Director of Care (DOC) acknowledged that PSW #102 did not use safe transferring and positioning techniques for resident #001.

The home has failed to ensure that staff used safe transferring and positioning devices and techniques when assisting residents #001 and #010.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #005 had been identified with skin integrity impairments on identified dates.

The clinical records of resident #005 were reviewed for an identified period and the weekly skin assessment for the skin integrity impairments were not completed as required.

RPN #103 and the ADOC acknowledged that it is the home's expectation that weekly skin assessments were conducted on any altered skin integrity until it had healed.

2. Resident #002 sustained a skin integrity impairment on an identified date.

A review of resident #008's weekly skin and wound assessments revealed that there was no assessment completed for an identified date and RPN #103 also confirmed this.

The ADOC, the lead for the home's Skin and Wound Program stated that any resident who had been identified with altered skin integrity, including skin tears, was to be assessed on a weekly basis using the weekly skin/wound assessment form in Point Click Care (PCC).

The licensee had failed to ensure that residents #002 and #005 who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written record relating to the Restorative care and Skin Care program evaluations included the date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

The home's annual evaluation for an identified year for the Restorative Care and Skin and Wound programs were reviewed and did not include the date when the changes were implemented for either program.

The ADOC and RCC acknowledged that the written records relating to the Restorative Care and Skin and Wound program evaluations did not include the dates when the changes were implemented. [s. 30. (1)

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location.

The inspector observed that the home's Abuse and Neglect policy and procedure was located in an area that was not visible and easily accessible to anyone.
The ADOC and RRC stated that the home's policy entitled, "Prevention of Abuse and Neglect of a Resident", was not posted where it is visible and easily accessible to anyone.

The licensee failed to ensure that the home's Prevention of Abuse and Neglect of a Resident policy was posted in the home, in a conspicuous and easily accessible location.

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), ZINNIA SHARMA (696)
Inspection No. / No de l'inspection :	2018_723606_0025
Log No. / No de registre :	022870-17, 023044-17, 023553-17, 026428-17, 006992-18, 007252-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 18, 2019
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodhall Park Care Community 10260 Kennedy Road North, BRAMPTON, ON, L6Z-4N7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kerri Judge

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with s. 19(1) of the LTCHA.
Specifically, the licensee shall ensure that resident #006 and any other residents are protected from abuse by anyone.

Grounds / Motifs :

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

A complaint submitted to the MOHLTC reported resident #006 was abused by resident #004 resulting in a serious injury.

Resident #004's progress notes stated that the resident unexpectedly pushed resident #006 while both residents were walking by each other resulting in resident #006 to fall.

PSWs #118 and #120, and RPN #130 stated that resident #004 was identified to display physical aggression that was at times unprovoked.They acknowledged that resident #004 pushed resident #006 to the floor.

The licensee has failed to ensure that resident #006 was protected from physical abuse. [s. 19. (1)]

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include severity, scope and history of non-compliance. In relation to s. 19(1) of Ontario Regulation 79/10,
The severity of the noncompliance was a level 3 actual harm/risk;
The scope of the non-compliance was a level 1 isolated and:
The history of non-compliance was a level 4 as despite MInistry of Health and Long Term Care (MOHLTC) action (Voluntary Plan of Correction (VPC) or Order) NC continues with original area of NC. (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54 (b) of O. Reg. 79/10.
Specifically, the licensee must ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions by resident #004 towards resident #006 and any other resident by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions.

A complaint and a CI report received by the MOHLTC reported a resident to resident altercation resulting in a serious injury.

Resident #004's progress notes stated that staff witnessed resident #004 pushed resident #006 resulting in resident #006 to fall.

Resident #004's progress notes were reviewed for an identified time period and revealed the resident had ongoing responsive behaviours towards staff and residents on a daily basis and at times displayed these behaviours unprovoked. The progress notes stated several incidents where resident #004 had an

altercation with another resident and staff.

Resident #004's care plan identified the resident with displaying responsive behaviours towards staff and directed several interventions to manage the resident's behaviours. The care plan did not provide further steps to address how to prevent and/or minimize resident #004 from getting into further altercations.

PSWs #118 and #120 stated that resident #004 was known to display responsive behaviours towards staff and residents despite the interventions in place. They stated that they witnessed resident #004 push resident #006. RPN #130 stated that resident #004 was known have display responsive behaviours towards others and stated that resident #004 pushed resident #006.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such altercations; and identifying and implementing interventions. [s. 54. (b)]

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include severity, scope and history of non-compliance. In relation to r 54(b) of Ontario Regulation 79/10,
The severity of the noncompliance was a level 3 actual harm/risk;
The scope of the non-compliance was a level 1 isolated; and
The history of non-compliance was a level 2 as one or more unrelated Non Compliance (NC) in the last 3 years. (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 18th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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