Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 19, 2013	2013_196157_0015	O-000401-13	Complaint

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)

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): May 16, 21, 22, 23, June 3, 7, 10, 12, 2013

During the course of the inspection, the inspector(s) spoke with The home's Chief Executive Officer (CEO), Acting Director of Care, Director of Care, two Unit Managers, 3 Registered Nurses (RN), 1 Registered Practical Nurse (RPN), 12 Personal Support Workers (PSW), one housekeeper, Education Coordinator, Registered Dietitian, Nutritional Care Manager, 7 residents, 5 family members, two detectives from the Peterborough Lakefield Community Police Service

During the course of the inspection, the inspector(s) reviewed the clinical health records for two residents, reviewed video clips provided by the family member of a resident, Critical Incident Reports, policies related to Behaviour Management, Infection Prevention and Control, Resident Abuse and Neglect - Zero Tolerance, Use of Restraints, reviewed staff education records, observed resident behaviours on Woodland Unit, observed processes for monitoring, reporting and managing responsive behaviours, observed staff:resident interactions and care and services provided to residents on all care units, observed meal and snack service on Woodland Unit.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Snack Observation

Findings of Non-Compliance were found during this inspection.

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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	Legendé 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to comply with LTCHA, 2007 s. 3(1)1. to respect the right of every resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Clips from a video camera in resident #001's room on three identified dates, show care being provided by staff for resident #001, and indicate the following:

- Video clip #OCGTB1P2 - Resident #001 was observed to be visibly, physically resisting the provision of care. Three staff members were observed to physically restrain the resident and forcefully proceed to provide care against the resident's wishes.
- Video clips #OCH5VVD2,OCH600D2 – Two staff members were observed to be engaging in inappropriate affectionate interactions in the presence of resident #001.
- Video clips #OCHK9UM2, OCHK9VM2 – A staff member was observed to be providing resident #001 with personal hygiene care and on two occasions held a face cloth soiled with feces very close to the resident's face.
- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes. [s. 3. (1) 1.]

2. The licensee failed to comply with LTCHA 2007, s. 3(1)5. to fully respect the resident's right to live in a safe and clean environment.

Clips from a video camera in resident #001's room on two identified dates, showing care being provided by staff to resident #001, indicate the following:
- Video clip #OCGPT612 - A staff member was observed providing care to resident #001 - the staff member is observed to remove a soiled incontinent product from the resident and place it on a chair in the resident's room
- Video clip #OCGPTAJ2- A staff member is observed to provide peri care to resident #001 and place the soiled cloth on a chair in the resident's room
- Video clip #OCH6OK9VM2 - A staff member is observed to make resident #001's bed with same sheet as was used to wipe the staff member's nose.
- Video clip #OCHK9VM2 - A staff member is observed to provide peri care to resident #001 and then throw the soiled cloth on the floor
- Video clip #OCHKA1L2 - A staff member is observed to be wearing gloves to provide peri care to resident #001 and then handle the resident's remote control with the same gloves

- Video clip #OCHKAOL2 - A staff member is observed using soiled clothing and linens to wipe the floor of resident's #001's room and then pick the soiled linen up and place it on the chair in the resident's room [s. 3. (1) 5.]

3. The licensee failed to comply with LTCHA 2007, s. 3(1)8. to fully respect the right of every resident to be afforded privacy in treatment and in caring for his or her personal needs.

Clips from a video camera in resident #001's room on ten identified dates, showing care being provided by staff to resident #001, indicate the following:

- Video clip #OCGIQ2HO – Staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGIQ490 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGLDQI0 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGLDTR0 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGN5CN2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGPTEQ2 - staff were observed to provide personal hygiene care to resident #001 with the door open and the resident visible from the corridor. A male resident was observed to be watching through the open door.
- Video clip #OCGVUHI2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGVUIJ2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCH2KSP2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the

corridor.
- Video clip #OCHAHQU2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHFODU2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHIC392 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHLGIG2 - staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHLGJH2 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor. [s. 3. (1) 8.]

Additional Required Actions:

CO # - 001, 009 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

The licensee failed to comply with O. Reg s. 6(1)(c) to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clip #OCGTB1P2 - Indicates two staff members entering the resident #001's room in the dark, turning on the overhead light and attempting to change the resident's clothing. The resident physically resisted and the two staff members attempted to forcefully control the resident with their hands. When the resident continued to resist, a third staff member assisted to apply physical control by holding the resident's wrists. A staff member interviewed, reported that 3 staff are sometimes used to provide care on this unit due to resident resistance and that at the time of this video the resident was very "feisty" - the resident was very wet and a third PSW was called to provide assistance.
Another staff member when interviewed, reported that is not unusual for resident #001 to be resistive to care.
- Video clips OCHK9N92, OCHK9OA2,OCHK9VM2,OCHKA0L2,and OCHKA1L2 - Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes.
- Staff interviewed confirm that it is usual behaviour for resident #001 to resist having care provided - Staff were unable to communicate a consistent approach or intervention used to manage this behaviour
- The written plan of care for resident #001 failed to identify the resident's resistive behaviour and fails to provide clear written direction to staff for the provision of care when the resident is resistive. [s. 6. (1) (c)]

2. The licensee failed to comply with O. Reg 79/10 s. 6(5) by ensuring that the resident's substitute decision maker(SDM)was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
Written documentation of a Care Conference convened with the resident's SDM, does not indicate that the management of resistive/aggressive behaviours or refusal of care was identified or discussed.
Written progress note entries for resident #001 indicate:
- Seven identified dates when the resident refused care

- Physician documentation indicates "resident remains resistive to care at times"

Progress notes for resident #001 indicate that the resident's POA reported never being told that the resident is aggressive.
In an interview, the resident's SDM advised the inspectors that prior to a recent "Special Conference", he had not been made aware of the resident's resistance to care and did not have the opportunity to participate fully in the development and implementation of the plan of care to manage these behaviours. [s. 6. (5)]

3. The plan of care for resident #0012, identified that the resident was to be redirected from other resident rooms and the resident's whereabouts were to be monitored.

Clips from a video camera in resident #001's room on five identified dates indicate the following:

- Video clip #OCGKBP90 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCGKK9OO - Resident #012 was observed to wander into resident #001's room without any redirection from staff.
- Video clip #OCGPTEQ2– Staff were observed to provide personal hygiene care to resident #001 with the door open and resident #001 was visible from the corridor. Resident #012 was observed to be watching through the open door without any redirection from staff.
- Video clip #OCH16EC2 – Resident #012 was observed to wander into resident #001's room, take something off the bedside table, without any redirection from staff.
- Video clip #OCHBJ862 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHC43L2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHK3LK2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHLGBP2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff

Staff interviewed indicated that they are aware of the direction provided in the plan of care for monitoring resident #012 but they follow it at their discretion when time allows.

Care was not provided to resident #012 as specified in the plan of care. [s. 6. (7)] (157)(194)

Additional Required Actions:

CO # - 002, 007 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to comply with s.19(1) by failing to protect residents from abuse by anyone.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clips #OCHK9UM2, OCHK9VM2 - A staff member was observed to be providing resident #001 with personal hygiene care and on two occasions held a face cloth soiled with feces very close to the resident's face. The resident's reaction to the staff's gesture was to push the staff member's hand away. At this time, the resident was calmly laying on the bed while personal care was being provided. In the licensee's investigation of this incident, the statement provided by the staff member stated that the resident began to slap the staff member and the purpose of showing the resident the cloth to prove that personal hygiene care was required. The statement provided by the staff member fails to provide a satisfactory explanation of the need for using intimidating and humiliating gestures while providing care to the resident.
The staff member's actions constituted emotional abuse as they demonstrated intimidating and humiliating gestures in the provision of care to resident #001.

- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes. The staff member was observed to be applying physical force to resident #001's left wrist while attempting to provide care. Following the altercation, the video clip showed resident #001 flexing and grasping the left wrist and hand in a manner that reflected pain, the resident was visibly shaken and observed to experience rapid and shallow breathing.
In the licensee's investigation of this incident, the statement provided by the staff member fails to provide a satisfactory explanation of the need for physical force or a reason why physical force was applied to the resident's left wrist. The staff member's actions constituted physical abuse as physical force was used in the provision of care causing resident #001 physical pain to the left wrist. [s. 19. (1)]

2. In an interview staff #119, Education Coordinator, stated that no education related to abuse and neglect or Resident's Bill of Rights was provided to staff in 2012.

The licensee's policy "Abuse and Neglect (resident)-Zero Tolerance" Policy #14-18 effective April 2011 fails to identify the training and retraining requirements for all staff

including:
i. Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

The licensee failed to comply with LTCHA, 2007, s.76.(7) to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents:
- annual training in the area mental health issues including caring for persons with dementia
- annual training in the area of behaviour management
Training and education records reviewed for 2012 identified that staff members #112, #113, #114, #115 did not receive the required training. [s. 76. (7) 2.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

The licensee's Policy "Abuse and Neglect (resident)-Zero Tolerance" Policy #14-18 effective April 2011 fails to identify the training and retraining requirements for all staff including:
i. Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations

Staff #119, Education Coordinator, was interviewed and advised that there was no staff education or training provided in 2012 related to abuse and neglect or Resident's Bill of Rights.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes.
- Video clip #OCGTB1P2 - Resident #001 was observed to be visibly, physically resisting the provision of care. Three staff members were observed to physically restrain the resident and forcefully proceed to provide care against the resident's wishes.
The video clips demonstrate a power imbalance between staff and resident #001 where body language clearly communicated the resident's wishes and the staff involved used the power of their position of authority to proceed to act contrary to the resident's wishes. [s. 96. (e)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

There is no evidence that an interdisciplinary team that coordinates and implements the infection control program meets at least quarterly. Infection Control Committee Minutes provided are undated but reference activities and events for June and July 2012. In a June 3, 2013 interview, the Unit Manager reported that there has not been an active interdisciplinary infection control team in place since January 2013. [s. 229. (2) (b)]

2. The licensee failed to comply with O. Reg s. 229(4) by ensuring that all staff participate in the implementation of the infection prevention and control program.

Clips from a video camera in resident #001's room on three identified dates show care being provided by staff to resident #001, and indicate the following:
- Video clip #OCGPT612 - A staff member was observed providing care to resident #001 - the staff member is observed to remove a soiled incontinent product from the resident and place it on a chair in the resident's room
- Video clip #OCGPTAJ2 - A staff member is observed to provide peri care to resident #001 and place the soiled cloth on a chair in the resident's room
- Video clip #OCH6OK9VM2 - A staff member is observed to make resident #001's bed with same sheet as was used to wipe the staff member's nose.
- Video clip #OCHK9VM2 - A staff member is observed to provide peri care to resident #001 and then throw the soiled cloth on the floor
- Video clip #OCHKA1L2 - A staff member is observed to be wearing gloves to provide peri care to a resident and then handle the resident's remote control with the same gloves
- Video clip #OCHKAOL2 - A staff member is observed using soiled clothing and linens to wipe the floor of resident's #001's room and then pick the soiled linen up and place it on the chair in the resident's room

The observed actions of the employees demonstrate that they failed to participate in the implementation of the infection prevention and control program.(157) [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s.71(3)(a) on an identified date when three residents on the Woodland E Unit, were not provided breakfast.
- In an interview, PSW #126 stated that resident #406 was provided a beverage at 1050 hours, but no breakfast because staff "ran out of time".
- PSW #125 stated that resident #408 was also provided a beverage at 1050 hours, but not offered breakfast.
- The four staff members working on the Woodland E unit were interviewed at 1130 hours about resident #411's breakfast status and were not able to confirm if the resident had been offered a breakfast.

The plans of care for all identified residents indicated that each of the residents was assessed to be at nutritional risk and required assistance at meals. [s. 71. (3)]

2. The licensee failed to comply with O. Reg 79/10 s.71(3)(b)when the morning beverage cart was not offered to residents on the Woodland E unit, as confirmed by the four PSW's working on the unit.

Nutritional care staff interviewed, stated that a nourishment cart is provided to all units in the morning, afternoon, and evening. The staff member interviewed also stated that the morning cart offers beverages only while the afternoon and evening cart offers beverage and snack for residents. The staff member confirmed that it is the responsibility of nursing staff to offer beverages and snacks on the cart to the residents on the unit. The staff member stated that the morning beverage cart is frequently returned to the kitchen "untouched" from the Woodland Unit, indicating that the residents have not received any beverages. [s. 71. (3) (b)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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 :

The licensee failed to comply with O. Reg s 53(4)(a) by ensuring the identification of behavioural triggers that may result in responsive behaviours for resident #012.

Resident #012's plan of care indicated the behaviours demonstrated by the resident but no triggers for the behaviour were identified .

2. The licensee failed to comply with O. Reg s. 53(4)(b) by ensuring the development of
strategies to respond to resident #001's behaviours. Staff interviewed advise that resident #001 frequently resists the provision of personal care.

The plan of care for resident #001 did not provide strategies to manage resistive behaviour. Staff were not able to communicate any consistent interventions used to manage these behaviours.

Clips from a video camera in resident #001's room on two identified dates show care being provided by staff to resident #001, and indicate the following:

- Video clip #OCGTB1P2 - Indicates two staff members entering the resident #001's room in the dark, turning on the overhead light and attempting to change the resident's clothing. The resident physically resisted and the two staff members attempted to forcefully control the resident with their hands. When the resident continued to resist, a third staff member assisted to apply physical control by holding the resident's wrists. Following the altercation, the resident was visibly shaken and was observed to have rapid and shallow breathing.

Staff member #113 when interviewed reported that 3 staff are sometimes used to provide
care on this unit due to resident resistance and that at the time of this video the resident was very "feisty", was very wet and a third PSW was called to provide assistance. Staff #113 stated that "short of walking away and leaving the resident wet, what can you do?"

Staff member #112 when interviewed reported that is not unusual for resident #001 to refuse or be resistive to care.

- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly,

physically resisting the provision of care. A staff member was observed to control the resident by restraining the resident's hands and forcefully proceed to provide care against the resident's wishes. Following the altercation, the resident was visibly shaken and was observed to have rapid and shallow breathing.

In an interview on June 12, 2013, the resident's Substitute Decision Maker expressed continued concerns about the manner in which the resident's personal care needs are being managed.

The plan of care for resident #001 failed to provide strategies to respond to the resident's resistive behaviours. [s. 53. (4) (b)] (194)(157)

Issued on this 26th day of June, 2013

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

Lynn Duchesne #117
for Patricia Powers #157

Ontario

Ministry of Health and Long-Term Care
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Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	CHANTAL LAFRENIERE (194) PAT POWERS (157)	**Inspector ID #**	196/154
Log #:	O-000401-13		
Inspection Report #:	2013_196157_0015		
Type of Inspection:	Complaint		
Date of Inspection:	May 16, 21, 22, 23, June 3, 7, 10, 12, 2013		
Licensee:	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8		
LTC Home:	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8		
Name of Administrator:	GARY SIMS		

To MARYCREST HOME FOR THE AGED, you are hereby required to comply with the following orders by the date set out below:

Order #:	901	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: 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).			
Grounds: The plan of care for resident #0012, identified that the resident was to be redirected from other resident rooms and the resident's whereabouts were to be monitored. Clips from a video camera in resident #001's room on five identified dates indicate the following:			

Video clip #OCGKBP90 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCGKK9OO - Resident #012 was observed to wander into resident #001's room without any redirection from staff.
- Video clip #OCGPTEQ2– Staff were observed to provide personal hygiene care to resident #001 with the door open and resident #001 was visible from the corridor. Resident #012 was observed to be watching through the open door without any redirection from staff.
- Video clip #OCH16EC2 – Resident #012 was observed to wander into resident #001's room, take something off the bedside table, without any redirection from staff.
- Video clip #OCHBJ862 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHC43L2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHK3LK2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff
- Video clip #OCHLGBP2 – Resident #012 was observed to wander into resident #001's room without any redirection from staff

Staff interviewed indicated that they are aware of the direction provided in the plan of care for monitoring resident #012 but they follow it at their discretion when time allows.

Care was not provided to resident #012 as specified in the plan of care. [s. 6. (7)] (157)(194)

This order must be complied with by:	June 19, 2013

Order #:	902	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, 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;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order: The licensee shall ensure the following will be established for each resident demonstrating resistive, wandering or aggressive behaviours:
1. Behavioural triggers, where possible, will be clearly identified for each identified behaviour with special attention to those behaviours where there is a risk of harm to the resident or others
2. Strategies are developed and implemented to respond to the identified behaviours
3. Ensure that staff are informed immediately when implemented strategies are not effective and the plan of care must be changed
4. An effective monitoring process is implemented and assigned to staff with supervisory responsibilities to ensure that the effectiveness of the monitoring program is evaluated every shift

Compliance is required by June 19, 2013.

Grounds:
1. The licensee failed to comply with O. Reg s 53(4)(a)by ensuring the identification of behavioural triggers that may result in responsive behaviours for resident #012.

Resident #012's plan of care indicated the behaviours demonstrated by the resident but no triggers for the behaviour were identified.

2. The licensee failed to comply with O. Reg s. 53(4)(b) by ensuring the development of strategies to respond to resident #001's behaviours. Staff interviewed advise that resident #001 frequently resists the provision of personal care.

The plan of care for resident #001 did not provide strategies to manage resistive behaviour. Staff were not able to communicate any consistent interventions used to manage these behaviours.

Clips from a video camera in resident #001's room on two identified dates show care being provided by staff to resident #001, indicate the following:

- Video clip #OCGTB1P2 - indicates two staff members entering the resident #001's room in the dark, turning on the overhead light and attempting to change the resident's clothing. The resident physically resisted and the two staff members attempted to forcefully control the resident with their hands. When the resident continued to resist, a third staff member assisted to physically control the resident by holding the resident's wrists. Following the altercation, the resident was visibly shaken and was observed to have rapid and shallow breathing.

Staff member #113 when interviewed reported that 3 staff are sometimes used to provide care on this unit due to resident resistance and that at the time of this video the resident was very "feisty", was very wet and a third PSW was called to provide assistance. Staff #113 stated that "Short of walking away and leaving the resident wet, what can you do?"

Staff member #112 when interviewed reported that is not unusual for resident #001 to refuse or be resistive to care.

- Video clips #OCHK9UM2, OCHK9VM2 – May 6, 2013 - Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to control the resident by restraining the resident's hands and forcefully proceed to provide care to the resident against the resident's wishes. Following the altercation, the resident was visibly shaken and was observed to have rapid and shallow breathing.

In an interview on June 12, 2013, the resident's Substitute Decision Maker expressed continued concerns about the manner in which the resident's personal care needs are being managed.

The plan of care for resident #001 last reviewed May 14, 2013, failed to provide strategies to respond to the resident's resistive behaviours. [s. 53. (4) (b)] (194)(157) (194)

This order must be complied with by:	June 19, 2013

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 service for the Licensee.

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

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

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

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

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
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.

Issued on this 14 day of June, 2013	
Signature of Inspector:	Lynn Duchesne for Pat Powers + Chantal Lafreniere
Name of Inspector:	Pat Powers/Chantal Lafreniere
Service Area Office:	OSAO

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_196157_0015
Log No. / Registre no:	O-000401-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 14, 19, 2013
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GARY SIMS

To MARYCREST HOME FOR THE AGED, 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. 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 shall ensure that every resident's right to be treated with courtesy, respect and dignity during the provision of personal care to residents demonstrating resistive behaviours is respected by:

1. Ensuring that the resident's plan of care provides interventions that reflect the resident's right to be treated with courtesy, respect and dignity.
2. Ensuring that staff receive education related to respect and promotion of resident's rights
3. Ensuring that the licensee's quality assurance process evaluates resident/family satisfaction related to respect and promotion of resident rights

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007 s. 3(1)1. to respect the right of every resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Clips from a video camera in resident #001's room on three identified dates, showing care being provided by staff for resident #001, indicate the following:

- Video clip #OCGTB1P2 - Resident #001 was observed to be visibly, physically resisting the provision of care. Three staff members were observed to physically restrain the resident and forcefully proceed to provide care against the resident's wishes.
- Video clips #OCH5VVD2,OCH600D2 – Two staff members were observed to be engaging in inappropriate affectionate interactions in the presence of resident #001.
- Video clips #OCHK9UM2, OCHK9VM2 – A staff member was observed to be providing resident #001 with personal hygiene care and on two occasions held a face cloth soiled with feces very close to the resident's face.
- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes. [s. 3. (1) 1.] (157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2013_196157_0013, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:
1. Ensure that the written plan of care for residents with resistive behaviours sets out clear direction to staff for the provision of care related to the identified behaviours. Specifically, care approaches and care techniques when providing care to residents with these identified behaviours.
2. Ensure that the care set out in the plan of care is communicated to all staff providing care.
3. When interventions are found to be ineffective, direct care staff will collaborate with registered nursing staff to determine alternative approaches.

Grounds / Motifs :

1. This order was issued on May 10, 2013 under report #2013_196157_0013, with a compliance date of May 17, 2013. This order will remain non compliant related to the following evidence:

The licensee failed to comply with O. Reg s. 6(1)(c) to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clip #OCGTB1P2 - Indicates two staff members entering the resident #001's room in the dark, turning on the overhead light and attempting to change the resident's clothing. The resident physically resisted and the two staff members attempted to forcefully control the resident with their hands. When the resident continued to resist, a third staff member assisted apply physical control the by holding the resident's wrists. A staff member interviewed, reported that 3 staff are sometimes used to provide care on this unit due to resident resistance and that at the time of this video the resident was very "feisty" - the resident was very wet and a third PSW was called to provide assistance.
Another staff member when interviewed, reported that is not unusual for resident #001 to be resistive to care.
- Video clips OCHK9N92, OCHK9OA2,OCHK9VM2,OCHKA0L2,and OCHKA1L2 - Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes.
- Staff interviewed confirm that it is usual behaviour for resident #001 to resist having care provided - staff were unable to communicate a consistent approach or intervention used to manage this behaviour
- The written plan of care for resident #001 failed to identify the resident's resistive behaviour and fails to provide clear written direction to staff for the provision of care when the resident is resistive. [s. 6. (1) (c)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 shall ensure that residents are protected from abuse :
1. By ensuring that excessive physical force is not used in the provision of care when assisting residents with resistive behaviours.
2. By ensuring that intimidating or humiliating gestures, actions, behaviour or remarks are not directed to a resident during the provision of care.
3. By providing annual education to all staff related to abuse and neglect and Resident's Bill of Rights.
4. By ensuring that the licensee's quality assurance process includes a mechanism to evaluate the effectiveness of the abuse and neglect and Resident's Bill of Rights education programs.

Grounds / Motifs :

1. This order was issued on May 10, 2013 under report #2013_196157_0013 with a compliance date of June 30, 2013.
- the development of a care planning process for residents with responsive behaviours
- the development of a monitoring process to ensure that the Director is immediately notified of alleged, suspected or witness incidents of abuse
- ensuring the provision of staff education related to legislative requirements for reporting incidents of abuse
- development of a process to monitor, evaluate and ensure compliance with the newly developed Responsive Behaviour Program

This order remains non compliant with the following additional evidence:

1. The licensee failed to comply with s.19(1) by failing to protect residents from

abuse by anyone.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clips #OCHK9UM2, OCHK9VM2 - A staff member was observed to be providing resident #001 with personal hygiene care and on two occasions held a face cloth soiled with feces very close to the resident's face. The resident's reaction to gesture was to push the staff member's hand holding the soiled cloth, away. At this time, the resident was calmly laying on her bed while personal care was being provided. In the licensee's investigation of this incident, the statement provided by the staff member stated that the resident began to slap the staff member and the purpose of showing the resident the cloth to prove that personal hygiene care was required. The statement provided by the staff member fails to provide a satisfactory explanation of the need for using intimidating and humiliating gestures while providing care to the resident.
The staff member's actions constituted emotional abuse as they demonstrated intimidating and humiliating gestures in the provision of care to resident #001.

- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes. The staff member was observed to be applying physical force to resident #001's left wrist while attempting to provide care. Following the altercation, the video clip showed resident #001 flexing and grasping the left wrist and hand in a manner that reflected pain, the resident was visibly shaken and observed to experience rapid and shallow breathing.
In the licensee's investigation of this incident, the statement provided by the staff member fails to provide a satisfactory explanation of the need for physical force or a reason why physical force was applied to the resident's left wrist. The staff member's actions constituted physical abuse as physical force was used in the provision of care causing resident #001 physical pain to the left wrist. [s. 19. (1)]

(194)

2. In an interview staff #119, Education Coordinator, stated that no education related to abuse and neglect or Resident's Bill of Rights was provided to staff in 2012.

The licensee's policy "Abuse and Neglect (resident)-Zero Tolerance" Policy #14-18 effective April 2011 fails to identify the training and retraining requirements for all staff including:
i. Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations [s. 19. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

1.The licensee shall ensure that all staff who provide direct care to residents receive annual training related to:
- mental health issues, including caring for persons with dementia
- behaviour management

2. The licensee shall ensure its quality assurance process evaluates the effectiveness of staff education

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s.76.(7) to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents:
- annual training in the area mental health issues including caring for persons with dementia
- annual training in the area of behaviour management
Training and education records reviewed for 2012 identified that staff members #112, #113, #114, #115 did not receive the required training. [s. 76. (7) 2.] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee shall ensure that the policy "Abuse and Neglect - Zero tolerance" clearly identifies the annual training and retraining requirements for all staff including:

1. Training related to power imbalances between staff and residents and the potential for resident abuse and neglect related to these imbalances.
2. Measures to recognize and prevent situations that may lead to abuse and neglect.

Grounds / Motifs :

1. The licensee's Policy "Abuse and Neglect (resident)-Zero Tolerance" Policy #14-18 effective April 2011 fails to identify the training and retraining requirements for all staff including:
i. Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations

Staff #119, Education Coordinator, was interviewed and advised that there was no staff education or training provided in 2012 related to abuse and neglect or Resident's Bill of Rights.

Clips from a video camera in resident #001's room on two identified dates, show care being provided by staff to resident #001, and indicate the following:

- Video clips #OCHK9UM2, OCHK9VM2 – Resident #001 was observed to be visibly, physically resisting the provision of care. A staff member was observed to forcefully proceed to provide care against the resident's wishes.
- Video clip #OCGTB1P2 - Resident #001 was observed to be visibly, physically resisting the provision of care. Three staff members were observed to physically restrain the resident and forcefully proceed to provide care against the resident's wishes.
The video clips demonstrate a power imbalance between staff and resident #001 where body language clearly communicated the resident's wishes and the staff involved used the power of their position of authority to proceed to act contrary to the resident's wishes. [s. 96. (e)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall ensure that all staff participate in the implementation of the infection control program by:
1. Ensuring that policies and procedures reflecting effective infection control practices are communicated to all staff.
2. Ensuring that an effective monitoring process is implemented and assigned to staff with supervisory responsibilities to ensure that all staff implement measures to prevent the transmission of infection.
3. Ensuring that the licensee's quality assurance process uses data collection and trend analysis to evaluate infection control program and practices in the home.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg s. 229(4) by ensuring that all staff participate in the implementation of the infection prevention and control program.

Clips from a video camera in resident #001's room on three identified dates show care being provided by staff to resident #001, and indicate the following:
- Video clip #OCGPT612 - A staff member was observed providing care to resident #001 - the staff member is observed to remove a soiled incontinent product from the resident and place it on a chair in the resident's room
- Video clip #OCGPTAJ2 - A staff member is observed to provide peri care to resident #001 and place the soiled cloth on a chair in the resident's room
- Video clip #OCH6OK9VM2 - A staff member is observed to make resident #001's bed with same sheet as was used to wipe the staff member's nose.
- Video clip #OCHK9VM2 - A staff member is observed to provide peri care to resident #001 and then throw the soiled cloth on the floor
- Video clip #OCHKA1L2 - A staff member is observed to be wearing gloves to provide peri care to a resident and then handle the resident's remote control with the same gloves
- Video clip #OCHKAOL2 - A staff member is observed using soiled clothing and linens to wipe the floor of resident's #001's room and then pick the soiled linen up and place it on the chair in the resident's room

The observed actions of the employees demonstrate that they failed to participate in the implementation of the infection prevention and control program. (157) [s. 229. (4)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall ensure that:
1. The Substitute Decision Maker for each resident is given the opportunity to participate fully in the development and implementation of the resident's plan of care on admission and as the resident's care needs change or the care set out in the plan is no longer necessary.
2. Ensure that the results of Care Conference decisions are communicated to all direct care staff.
3. The licensee's quality assurance process evaluates resident/family satisfaction related to their participation in the development and implementation of the resident's plan of care.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg 79/10 s. 6(5) by ensuring that the resident's substitute decision maker(SDM)was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
Written documentation of a Care Conference convened with the resident's SDM, does not indicate that the management of resistive/aggressive behaviours or refusal of care was identified or discussed.
Written progress note entries for resident #001 indicate:
- Seven identified dates when the resident refused care
- Physician documentation indicates "resident remains resistive to care at times"

Progress notes for resident #001 indicate that the resident's POA reported never being told that the resident is aggressive.
In an interview, the resident's SDM advised the inspectors that prior to a recent "Special Conference", he had not been made aware of the resident's resistance to care and did not have the opportunity to participate fully in the development and implementation of the plan of care to manage these behaviours. [s. 6. (5)] (194)

This order must be complied with by /
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Ontario

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that when direct care staff are unable, for any reason, to provide nutritional care to residents, such as serving breakfast and morning beverages, supervisory staff are immediately notified and remedial actions are taken.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg 79/10 s.71(3)(a) on June 7, 2013 when residents #406, #408, #411 on the Woodland E Unit, were not provided breakfast.
- In an interview, PSW #126 stated that resident #406 was provided a beverage at 1050 hours, but no breakfast because the staff "ran out of time".
- PSW #125 stated that resident #408 was also provided a beverage at 1050 hours, but not offered breakfast.
- The four staff members working on the Woodland E unit were interviewed at 1130 hours about resident #411's breakfast status and were not able to confirm if the resident had been offered a breakfast.

The plans of care for all identified residents indicates that each of the residents is assessed to be a high nutritional risk and require assistance to eat. [s. 71. (3)]

2. The licensee failed to comply with O. Reg 79/10 s.71(3)(b) on June 7, 2013 when the morning beverage cart was not offered to residents on the Woodland E unit, as confirmed by the four PSW's working on the unit.

Nutritional care staff interviewed, stated that a nourishment cart is provided to all units in the morning, afternoon, and evening. The staff member interviewed also stated that the morning cart offers beverages only while the afternoon and evening cart offers beverage and snack for residents. The staff member confirmed that it is the responsibility of nursing staff to offer beverages and snacks on the cart to the residents on the unit. The staff member stated that the morning beverage cart is frequently returned to the kitchen "untouched" from the Woodland Unit, indicating that the residents have not received any beverages. [s. 71. (3) (b)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 009

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 shall ensure that every resident's right to be afforded privacy in caring for his or her personal needs by:
1. Ensuring that policies and procedures reflecting the residents' right to privacy is respected by staff when caring for personal needs.
2. Ensuring that staff receive education related to respect and promotion of resident's rights to privacy.
3. Ensuring that an effective monitoring process is implemented and assigned to staff with supervisory responsibilities to ensure that all staff implement measures to respect residents' privacy when providing care.
4. The licensee's quality assurance process evaluates resident/family satisfaction related to respect for resident privacy in the provision of care.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, s. 3(1)8. to fully respect the right of every resident to be afforded privacy in treatment and in caring for his or her personal needs.

Clips from a video camera in resident #001's room on ten identified dates, showing care being provided by staff to resident #001, indicate the following:

- Video clip #OCGIQ2HO – Staff were observed to be providing personal care to

resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGIQ490 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGLDQI0 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGLDTR0 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGN5CN2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGPTEQ2 - staff were observed to provide personal hygiene care to resident #001 with the door open and the resident visible from the corridor. A male resident was observed to be watching through the open door.
- Video clip #OCGVUHI2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCGVUIJ2 - staff were observed to be providing personal care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCH2KSP2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHAHQU2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHFODU2 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHIC392 - 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.
- Video clip #OCHLGIG2 - staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor.

- Video clip #OCHLGJH2 – 2 staff were observed providing personal hygiene care to resident #001 with the door to the corridor open and the resident visible to the corridor. [s. 3. (1) 8.] (157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of June, 2013

Signature of Inspector / Signature de l'inspecteur : Lynn Duchesney #117 for Patricia Powers #157.

Name of Inspector / Nom de l'inspecteur : PATRICIA POWERS

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