Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2018	2018_621547_0023	012153-18	Resident Quality Inspection

Licensee/Titulaire de permis

Royal Ottawa Health Care Group
1141 Carling Avenue OTTAWA ON K1Z 7K4

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

Royal Ottawa Place
1145 Carling Avenue OTTAWA ON K1Z 7K4

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

LISA KLUKE (547), JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 19, 20, 21, 22, 25, 26, 27, 28, 29, 2018

The following intakes were completed concurrently during this Resident Quality Inspection:
Critical Incidents:
Logs #029081-17, 004001-18 and 011640-18, CIS #2933-000017-17, 2933-000005-18 and 2933-000007-18 related to missing resident>3 hours,
Log #016599-17, CIS #2933-000010-17 related to alleged resident to resident abuse,
Log #013069-18, CIS #2933-000008-18 related to alleged staff to resident abuse, and
Follow-up to order:
Log #006764-18 related to the designation of licensed beds as preferred accommodation.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Care Attendants (PCA), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping and Maintenance staff, Security Guards, the Office Coordinator, an Occupational Therapist (OT), a Physiotherapy Assistant (PTA), the Manager of Resident and Family Services and the Administrator/Director of Care.

In addition, the inspector(s) reviewed resident health care records, Resident's Council minutes, documents related to manufacturers instructions for equipment, the home's investigations into critical incidents submitted by the Licensee and policies and procedures related to abuse, Critical incident reporting, After hours Manager on call, Lifts and Transfers, Curfew, Proxy Cards and agreement, unsupervised resident outdoor access and agreement, and medication incidents. The inspectors observed the delivery of resident care and services and staff to resident as well as resident to resident interactions. The Inspectors reviewed medication administration and storage areas. The inspectors also reviewed internal investigation documents, employee training information, employee schedules, work assignments and employee records relevant to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

11 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 260.	CO #001	2018_621547_0004	547

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 resident #008 was protected from abuse by

PCA #113 in the home.

This inspection is related to log #013069-18.

On a specified date, the Licensee reported an alleged, suspected incident of staff to resident emotional abuse. The Critical incident report submitted indicated the incident occurred on a specified date whereby PCA #113 was emotionally abusive towards resident #008.

Resident #008 reported to inspector #547 after this incident of feeling intimidated, ignored and pushed around by PCA #113 during the resident's personal care provision before the supper meal. Resident #008 indicated having reported this concern to PCA #107 who then reported it to RPN #105 that evening.

PCA #107 indicated to inspector #547 during an interview, that resident #008's call bell cord was observed on the floor upon entering the resident's room before the supper meal on this specified date of the incident. PCA #107 indicated finding the location of the call bell cord odd as resident #008 is alert and oriented and can direct the PCA staff for personal care needs and preferences. Resident #008 reported to PCA #107 of being abused by PCA #113. PCA #107 reported this to RPN #105 immediately.

RPN #105 indicated to inspector #547 to have been made aware of an incident between PCA #113 and resident #008 on the date of the incident. RPN #105 immediately interviewed resident #008 and called charge RN #109. RPN #105 further indicated PCA #113 was not a regular nursing staff in the home as contracted in from an agency.

RPN #105 indicated to inspector #547 that an agency PCA insisted that resident #008 stay in bed and would feed the resident in bed and then took away the resident's call bell. RPN #105 indicated going to see resident #008 who was lying in bed with a call bell attached and appeared to be very upset saying " agency PCA #113 was not listening to me and took my call bell away twice". RPN #105 indicated that resident #008 is alert and oriented and has never seen the resident so upset. RPN #105 reassured the resident and indicated that they would keep agency PCA #113 away from the resident for the rest of the evening. RPN #105 reported to inspector #547 that this was abusive behaviour towards resident #008 as over powering the resident and taking away the resident's method to communicate to other staff in the home. RPN #105 indicated this incident was reported as per their internal procedures to the charge RN #109 and RPN #108 immediately.

Interviews were conducted with RN #109 and RPN #108 as charge staff in the home that evening by inspector #547. Both registered nursing staff members indicated to inspector #547 that they were aware that an incident between an agency staff member and a resident occurred on the unit as reported to them by RPN #105, however they did not immediately report this to the After Hours Manager, to the Administrator/Director of Care, or to the Director under the Long-Term Care Home's Act as required.

RN #109, RPN #108 or RPN #105 did not comply with the home's policy and procedure for Zero Tolerance of Resident Abuse and Neglect regarding this incident of alleged suspected resident abuse.

The incident was not investigated until two days after the incident occurred.

The appropriate police force was not informed until 19 days after the incident occurred.

Charge RN #109 and agency PCA #113 were not trained on the Licensee's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities with resident #008 on the date of the incident.

RPN #108 and Charge RN #109 had agency PCA #113 removed from resident #008's care duties after being made aware of this incident, but agency PCA #113 continued to work with residents in the home for the remainder of the evening shift on the date of the incident and returned to work with resident's in the home for the evening shift the following day. An incident occurred between agency PCA #113 and PCA #107 on the evening shift of the following day. PCA #107 reported to the evening Charge RN #119 that agency PCA #113 threatened PCA #107 for reporting the emotional abuse incident between agency PCA #113 and resident #008 the evening prior. RN #119 reported this concern to the After Hours Manager for the home, who removed agency PCA #113 from the home.

No investigation to the incident of resident #008 from the date of the incident occurred until the Administrator/Director of Care was made aware of the allegation of resident abuse two days later from reading an email from the After Hours Manager related to the threats made to PCA #107. Once the Administrator/Director of Care reviewed the allegations of the incident of staff to staff threat, was when the Administrator/Director of Care realized the staff to resident abuse that occurred in the home was not investigated or reported as required.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions
Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has specifically failed to ensure that:

(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and
(c) a written record is kept of everything required under clauses (a) and (b)

Inspector #550 reviewed the medication incidents for a specified three month period, during which there were two documented incidents. The first incident reviewed documented on the report that the medication pack for resident #023 for administration at a specified time and date was missing. The second incident reviewed from a specified date and time documented that resident #022 was administered the wrong narcotic medication. The resident was administered one type of narcotic medication by RPN #110 instead of two tablets of another type of narcotic medication. The inspector also reviewed the minutes from the home's medication error meeting which the Administrator/DOC identified as being the medication incident review for the period identified above. The inspector was unable to find documentation of the analysis related to these two incidents. [s. 135. (2)]

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 all medication incidents and adverse drug reactions are documented, reviewed, analyzed and a written record is kept of everything required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the care set out in the plan of care is provided to resident #008 as specified in the plan related to transfers and repositioning needs.

Resident #008 was admitted to the home with several medical diagnoses including a specified autoimmune disorder that primarily affects joints. Resident #008's plan of care related to positioning and transfers indicated the resident was fully dependent on staff and required two staff members to provide care including bed mobility.

On a specified date, resident #008 reported to inspector #547 that agency PCA #113 repositioned the resident in bed alone on a specified date during the evening that caused the resident to have a skin tear. The resident indicated it occurred while the agency PCA was trying to adjust a transfer sheet beneath the resident independently versus waiting for assistance of the second PCA and must have caught the resident's limb as it was noted to be bleeding after this intervention.

RPN #105 indicated to inspector #547 that the resident sustained a skin tear to limb on a specified date during the repositioning of the resident before the supper meal and required a dressing to be applied. RPN #105 indicated resident #008's skin is very fragile and the reason they need to use the transfer sheet under the resident, versus manipulating the resident's skin.

PCA #107 indicated to inspector #547 that resident #008 was observed to be bleeding to a specified limb while in bed before the supper meal on this specified date. The resident reported to PCA #107 at that time, that the agency PCA #113 repositioned the resident independently instead of waiting to have a second staff to assist with repositioning the resident in bed.

As such, agency PCA #113 did not follow resident #008's plan of care related to repositioning that resulted in skin tear to a specified limb. [s. 6. (7)]

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 :

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

This inspection is related to log #013069-18.

A Critical incident report submitted on a specified date indicated an incident of alleged suspected staff to resident emotional abuse occurred on another specified date with resident #008. The incident was reported to RPN #105 who then reported this to charge RN #109 and RPN #108. This incident was not immediately reported to the Administrator/Director of Care or the After Hours Manager. No investigation to this staff to resident alleged emotional abuse incident was done until two days after the incident occurred with resident #008. No report to the Director of the Ministry of Health and Long-Term Care was done until three days after the incident occurred. No report to the appropriate police force was made until 19 days after the incident occurred.

The Licensee's policy and procedure #110 titled Zero Tolerance of Resident Abuse and Neglect last revised May 24, 2017 was provided to inspector #547 by the Administrator/ Director of Care. The policy and procedure stated the following:

The ROHCG-ROP-LTC requires a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based on to the Director of Care/Administrator or after hours manager and the Director at the Ministry of Health and Long-Term Care regarding abuse of a resident by anyone or neglect of a resident by the Licensee or staff that resulted in harm or a risk of harm to the resident.

The Procedure stated on page 4 of 9:
6.1 The ROHCG shall make all staff at the ROP-LTC aware of the Zero Tolerance of Abuse policy with the expectation that they will comply with it. Upon hire, and annually

thereafter, all ROP-LTC staff will receive in-service education on the topic of abuse and neglect and the reporting of abuse and neglect. This education will include 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 care.

The Procedure stated on page 5 of 9:
6.1.1
-Immediately inform the RN and /or DOC/ delegate, of the situation. The DOC/delegate will advise a member of Senior Administration as appropriate.
-Provide a clearly written and signed statement of the facts in relation to the suspected abuse.

6.1.3
-Investigate all incidents of alleged suspected abuse
-Contact the police of suspected abuse as appropriate
-Document a detailed report describing the incident including: what happened, time and date that the incident occurred, who was involved including witnesses, possible reason for the incident, and actions taken to all phases of the investigation.
-Interview with resident involved as soon as possible noting all responses accurately
-Interview all staff who worked on the shift involved
-Obtain written signed statements from witnesses
-Report to the MOHLTC all incidents of suspected abuse of a resident by telephone and complete a critical incident report on line
-For incidents implicating staff, if as judged by the DOC or Senior Administration the circumstances are sufficiently serious to warrant immediate suspension of the implicated staff member, this action may be taken

The Administrator/Director of Care indicated to inspector #547 that RN #109 was in charge for the evening shift on a specified date of this incident. The Licensee provided RPN #108 to assist RN #109 with orientation to the home's processes. The Administrator/Director of Care indicated that RN #109 had not received education on the Licensee's policy and procedure for Zero Tolerance of Abuse and Neglect as required. RPN #108 indicated to inspector #547 during this inspection, to be responsible for assisting RN #109 with the home's processes such as routines and documentation in the home's electronic documentation system. RPN #108 indicated the Charge RN remained responsible for decisions made during this specified date.

The Manager of Resident and Family services indicated that upon contacting PSW

#113's agency, that PSW #113 had not been provided the education on the Licensee's policy and procedure for Zero Tolerance of Abuse and Neglect prior to work on the specified date of this incident as identified in WN #8.

As such, on this specified date of this incident RN #109 or RPN #108 did not follow the Licensee's policy and procedure to provide an effective response to actual or suspected incidents of abuse as reported by residents, staff and/or families. On the day following this incident, the After Hours Manager did not follow the Licensee's policy and procedure for Zero Tolerance of Abuse and Neglect regarding immediate investigation and reporting to the Licensee as well as the Director about the incident of alleged staff to resident abuse that occurred the previous day as required. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected incident of staff to resident abuse that the licensee knows of or that is reported, is immediately investigated.

This inspection is related to log #013069-18.

The Licensee reported via critical incident reporting an alleged, suspected staff to

resident emotional abuse of resident #008 that had occurred on a specified date and time. The critical incident report indicated resident #008 requested to get out of bed for supper and was told no by PCA #113 in a harsh tone. The critical incident indicated PCA #113 was not a regular staff member and worked for an agency. Resident #008 reported that PCA #113 put the resident's call bell cord out of reach and refused to give it to the resident. Resident #008 was reported to be frightened and scared and told the PCA to leave the resident's room and get another staff member.

As per O.Reg.79/10, s.2(1) emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Resident #008 indicated to inspector #547 to have been abused by a PCA a few weeks earlier. Resident #008 described PCA #113 as intimidating and pushy with resident #008 and would not listen to the resident. Resident #008 indicated PCA #113 had never worked with the resident before, and proceeded to reposition the resident indicating that the resident could not go for dinner in the dining room that night and took the resident's call bell away from the resident. Resident #008 indicated to have felt frightened and scared of PCA #113. Resident #008 indicated having reported this to RPN #105 and PSW #107 immediately.

RPN #105 indicated to inspector #547 to have been made aware of an incident between PCA #113 and resident #008 on a specified date. RPN #105 immediately interviewed resident #008 and called charge RN #109 working with RPN #108.

RN #109 indicated to Inspector #547 to have not began any investigation to this incident and did not understand the incident as abuse. RN #109 further indicated to have delegated resident #008 interview to RPN #108. RN #109 did not interview other nursing staff working on the resident's unit that evening including PCA #113 about this incident.

RPN #108 indicated they were informed of an incident between resident #008 and PCA #113 on a specified date. RPN #108 indicated that the resident was already in the dining room when they arrived to the resident's unit and was informed by another PCA in the home to go see the resident in the dining room as the resident was very upset about some incident that occurred before supper. RPN #108 indicated to have interviewed resident #008, who was visibly upset. RPN #108 indicated the resident reported that PCA #113 spoke harshly to the resident that evening and would not listen to the resident

during the provision of personal care. Resident #008 reported that PCA #113 refused to get the resident out of bed for supper as per usual practice and took the resident's call bell away from the resident on two separate occasions during the provision of personal care. RPN #108 reported this interview related to this incident to RN #109 who directed RPN #108 to remove PCA #113 from caring for resident #008 for that evening and to inform this change in routine to PCA #113 and RPN #105. RPN #108 indicated to RPN #105 to ensure that PCA #113's duties were readjusted to no longer care for resident #008 for the remainder of the evening. RPN #108 indicated the registered nurses usually ask more questions when there is suspected abuse, however followed RN #109's direction as they were busy with the RN's orientation to the home. RPN #108 further indicated to RPN #105 to send an email to the Administrator/Director of care about this incident that evening. RPN #108 indicated not having investigated this incident further.

The Administrator/Director of Care indicated that agency PCA #113 continued to work the remainder of the evening shift on this specified date with other residents in the home and returned to work the following evening until Agency PCA #113 threatened PCA #107 regarding the staff to resident #008 incident the previous day. PCA #107 reported this threat to RN #119 who immediately called the After Hours Manager that evening. The After Hours Manager had Agency PCA #113 removed from the home. The Administrator/Director of Care indicated to inspector #547 that no email was received from RPN #105 on the specified date of the incident. The Licensee began their investigation to the incident alleged staff to resident emotional abuse on two days later when the Administrator/Director of Care was informed by the After Hours Manager of the threat made by PCA #113 to PCA #107 that occurred. [s. 23. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #026 had occurred, immediately report the suspicion and the information upon which it was based to the Director.

This inspection was related to log #016599-17.

On a specified date, the Licensee reported a critical incident of resident to resident sexual abuse that occurred the previous day.

RN #112 reported to inspector #547 to have witnessed the incident of sexual abuse towards resident #026 by resident #025 at a specified date and time in the dining room. Resident #026 was seated in the dining room sleeping when resident #025 was observed to touch resident #026's to a specified body area with both hands. RN #112 immediately separated the residents and informed resident #025 that this was inappropriate behaviour. Resident #026 remained sleeping during this incident and was not aware of what had occurred. RN #112 reported this incident to the After Hours Manager.

The Administrator/Director of Care indicated to inspector #547 that the After Hours Manager working that evening did not report this incident of witnessed resident to resident sexual abuse to the Director as required, as this After Hours Manager was new and was not aware of the Long-Term Care reporting requirements and that the Critical

incident report was submitted the following day, 17 hours after the incident occurred. [s. 24. (1)]

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

This inspection is related to log #013069-18.

On a specified date, the Licensee reported an incident of alleged, suspected staff to resident emotional abuse of resident #008 that had occurred two days earlier. This incident was initially reported by the Manager of Resident and Family Services to the Director via the after hours reporting phone line. The critical incident report was submitted to the Director four days after the incident occurred by the Licensee, indicated resident #008 requested to get out of bed for supper and PCA #113 said no in a harsh tone. The critical incident indicated PCA #113 was not a regular staff member and worked for an agency and that resident #008 reported that PCA #113 put the resident's call bell cord out of reach and refused to give it to the resident on two separate occasions during the provision of care before the supper meal that evening. Resident #008 was reported to be frightened and scared.

As per O.Reg.79/10, s.2(1) emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Inspector #547 reviewed the Licensee's investigation package related to this incident. The Manager of Resident and Family Services interviewed PCA #107 who indicated having observed the resident's call bell cord on the floor upon entering the resident's room before supper on the specified date of the incident. PCA #107 indicated resident #008 is alert and oriented and can direct the PCA staff for the resident's personal care, and always requests the call bell to be attached within the resident's reach. Resident #008 indicated to PCA #107 of being abused by agency PCA #113 and PCA #107 reported this to RPN #105 immediately.

Resident #008 indicated to inspector #547 to have been abused by a PCA a few weeks earlier. Resident #008 described PCA #113 as intimidating and pushy with resident #008 and would not listen to the resident's requests. Resident #008 indicated PCA #113 had

never worked with the resident before and proceeded to reposition the resident indicating that the resident could not go for dinner in the dining room that night and took the resident's call bell away from the resident on two separate occasions during this incident. Resident #008 reported to have felt frightened and scared of PCA #113 not knowing what would happen next. Resident #008 indicated having reported this information to the regular nursing staff that evening, PCA #107 and RPN #105.

RPN #105 indicated to inspector #547 that an agency PCA working with the resident that evening, insisted that resident #008 stay in bed and would feed the resident in bed and then took away the resident's call bell. RPN #105 indicated going to see resident #008 who was lying in bed with a call bell attached and appeared to be very upset saying " PCA #113 was not listening to me and took my call bell twice". RPN #105 indicated that resident #008 is alert and oriented and has never seen the resident so upset. RPN #105 reassured the resident and indicated that they would keep PCA #113 away from the resident for the rest of the evening. RPN #105 reported to inspector #547 of not being aware that PCA #107 had already found the call bell cord on the floor and spoke to the resident, returning the call bell cord to the resident. RPN #105 perceived this incident was abusive behaviour towards resident #008 as over powering the resident and taking away the resident's method to communicate to other staff in the home that made resident #008 so angry and frightened. RPN #105 indicated this incident was reported to charge RN #109 as per their internal procedures immediately.

RN #109 indicated to inspector #547 to have been oriented to the home that day and working with RPN #108 during the evening shift. RN #109 indicated they were made aware of this incident on the date of the incident during the supper meal. RN #109 indicated that the After Hours Manager or the Administrator/Director of Care was not informed of this incident as RN #109 thought it was a difference of opinion/personalities and to separate the resident from this staff member was sufficient for that evening. RN #109 further indicated not having interviewed resident #008 after this incident occurred. RN #109 lastly indicated that the Director (Director of the Ministry of Health and Long-Term Care) was not informed as the RN was not aware this was required.

The Administrator/Director of care indicated to inspector #547 to have been made aware of a staffing incident that occurred on a specified date after reading an email from the After Hours Manager two days after the incident occurred. The Administrator/Director of Care realized this staffing incident occurred as a result of an alleged incident of staff to resident abuse on a specified date and asked the Manager of Resident and Family Services to interviewed resident #008 regarding this alleged staff to resident abuse. The

Manager of Resident and Family Services interviewed resident #008 three days after the incident occurred and was provided the resident's details of the staff to resident incident of abuse.

The Manager of Resident and Family Services indicated to inspector #547 to have called the Director to report this staff to resident emotional abuse, three days after the incident occurred. [s. 24. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a specified Personal Assistive Services Device (PASD) that was used to assist resident #005 with a routine activity of living was included in the residents' plan of care.

On a specified date, Inspector #547 observed resident #005 seated in a manual wheelchair with a specified PASD device applied to the resident that provided a gap of approximately five inches between the resident and the PASD.

PCA #102 indicated to inspector #547 that resident #005's specified PASD device was not properly applied and needed to be readjusted as it was not properly sized for the resident. PCA #102 indicated that the resident does not need this PASD any longer and that the PCA applied it as the device is attached to the resident's wheelchair.

RN #104 indicated to inspector #547 that resident #005 no longer needed to use this specified device while in a wheelchair. RN #104 indicated the resident is currently waiting for a new wheelchair and is positioned in a borrowed wheelchair that had this specified device installed. RN #104 asked maintenance #115 to remove this device from resident

#005's borrowed wheelchair as it was too loose and no longer required for the resident.

Maintenance staff #115 indicated to inspector #547 that the specified PASD device was removed from resident #005's borrowed wheelchair as it was too big for the resident and should never have been applied to the resident.

Inspector #547 reviewed resident #005's health care records that indicated on a specified date the resident was referred to an Occupational Therapist (OT) for a seating assessment. The resident's progress notes indicated resident #005 was assessed by OT #116 on another specified date and would greatly benefit from the use of a specified style wheelchair with specified PASD device to support neutral positioning when seated. Tilt action and a specified device are both considered as PASD's given their positioning benefits to sustain neutral sitting position. A few weeks later, the resident was documented as pushing the specified device to the floor three times from agitation. Approximately two months later, the resident was documented to be leaning to the left side and supported by a pillow when repositioned in the wheelchair. Approximately one month later, the resident was reassessed to no longer require the use of the specified device. Progress notes on two specified dates later, OT #116 indicated the resident's wheelchair dispensed on loan meets the mobility and positioning needs for resident #005.

OT #116 indicated to inspector #547 to have been referred to assess resident #005's seating and requested a loan wheelchair from a specified medical supply company on a specified date as well as a specified device to be applied to the resident as PASD. OT #116 kept documentation notes of this assessment of the resident once the equipment had arrived, to indicate the resident was seated in a specific wheelchair with the specified device applied. OT #116 further indicated that this specified device would have been verified to ensure that it was properly adjusted for the resident at that time. OT #116 indicated that the registered nursing staff are required to add information related to the resident's seating needs to the resident's plan of care.

Resident #005's plan of care was reviewed by inspector #547 for a specified three evaluation periods, whereby the use of this specified style wheelchair or specified PASD device was not documented in the resident's plan of care. [s. 33. (3)]

WN #8: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that RN #109 and PSW #113 received training on the Licensee's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

This inspection is related to log #013069-18.

On a specified date the Licensee reported an incident of alleged suspected staff to resident emotional abuse that occurred on four days earlier. The critical incident report indicated resident #008 reported to the Manager of Resident and Family Services that an agency PCA #113 was abusive with the resident, in speaking in harsh tone, refusing to get the resident up for supper and not listening to the residents requests, and then taking away the resident's call bell cord twice to prevent the resident from calling other staff

members. The critical incident report indicated the resident was frightened and scared.

The Administrator/Director of Care indicated to Inspector #547 to not have been made aware of the details of this allegation until three days after the incident occurred when the Manager of Resident and Family Services interviewed the resident. The Administrator/Director of Care indicated being aware of an incident between resident #008 and agency PCA #113 that then caused another incident between agency PCA #113 and the Licensee's PCA #107 but was not aware of the details of this incident. The Licensee's investigation documented that RPN #105 reported the incident to Charge RN #109 who worked on the evening of the specified incident accompanied by RPN #108. Charge RN #109 was oriented to the Long-Term Care home during the day shift and remained in the home to cover the evening shift charge RN duty. RN #109 did not receive training on the Licensee's policy to promote zero tolerance of abuse and neglect of residents prior to performing responsibilities as charge RN in the home.

The Manager of Resident and Family Services indicated to inspector #547 that upon the Licensee's investigation to this incident of alleged suspected staff to resident abuse, that the agency PCA #113 worked for, had not provided the Licensee's zero tolerance of abuse training as required prior to performing any responsibilities with resident's in the home. The Manager of Resident and Family Services indicated that the agencies are required to provide staff to the home that have been trained with the Licensee's policies as part of their contractual agreement. [s. 76. (2) 3.]

2. The licensee has failed to ensure that Charge RN #109 received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

Charge RN #109 working on the evening of a specified date was not provided this training in the area of mandatory reporting. An incident of alleged suspected staff to resident emotional abuse occurred on that shift, that caused resident #008 to be frightened and scared. Charge RN #109 did not report this incident to the After Hours Manager or to the Director as required. [s. 76. (2) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an incident of alleged, suspected incident of staff to resident emotional abuse of resident #008 on a specified date.

This inspection was related to log #013069-18.

On a specified date, four days after the incident the Licensee reported a critical incident report regarding an alleged, suspected incident of staff to resident #008 abuse that occurred in the home.

The Manager of Resident and Family Services indicated to Inspector #547 that the police force was not immediately notified. The Manager of Resident and Family Services notified the appropriate police force on a specified date, 19 days after the incident occurred. [s. 98.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer’s instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a specified Personal Assistive Services Device (PASD) used under section 33 of the Act for resident #005 was applied by staff in accordance with the manufacturer's instructions.

On a specified date inspector #547 observed resident #005 to be seated in a specified style wheelchair in the lounge with specified PASD device applied. Resident #005's specified PASD device was noted to be very loose, providing a gap of approximately five inches between the resident's body and the specified device.

PCA #102 indicated to inspector #547 that the resident's specified device was too loose and supposed to have a gap of two finger width only. PCA #102 further indicated that the specified device was no longer required for resident #005 and that it was applied to the resident that day as it remained attached to the resident's wheelchair in error.

RN #104 indicated that the specified PASD device was no longer required to be used for resident #005 and requested Maintenance staff #115 remove it immediately to prevent it from being applied to the resident any longer.

Occupational Therapist (OT) #116 indicated to inspector #547 that the specified device was assessed for resident #005 as a PASD for proper positioning of the resident while seated in this specified style wheelchair. OT #116 indicated that the specified PASD device would have been too loose, if observed applied to the resident with an approximate gap of five inches. OT #116 provided a copy of the manufacturers' instructions for this positioning device that indicated keeping the it firmly in position, attached to the wheelchair in places to assure that the specified body part does not move from an aligned, stable position and stays securely against the seat and back supports.

As such, the specified PASD applied by PCA #102 was not in accordance with the manufacturer's instructions as required by this section. [s. 111. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During a review of the licensee's medication incident reports, inspector #550 noted documented on a medication incident report from a specified date and time, that resident #022 was administered one tablet of specified narcotic medication by RPN #110 instead of two tablets of another narcotic medication. Documentation in the resident's progress notes confirmed this incident and indicated that the resident did not suffer any ill effects from this incident.

As such, the licensee failed to ensure that resident #022 was administered the specified narcotic medication as prescribed. [s. 131. (2)]

Issued on this 26th day of November, 2018

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

Original report signed by the inspector.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547), JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2018_621547_0023
Log No. / No de registre :	012153-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 26, 2018
Licensee / Titulaire de permis :	Royal Ottawa Health Care Group 1141 Carling Avenue, OTTAWA, ON, K1Z-7K4
LTC Home / Foyer de SLD :	Royal Ottawa Place 1145 Carling Avenue, OTTAWA, ON, K1Z-7K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nicoleta Burcea

To Royal Ottawa Health Care Group, 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. 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 Long-Term Care homes Act, 2007.

Specifically the Licensee shall take the necessary corrective actions to ensure that all staff providing direct care to residents as well as all staff in a supervisory or managerial position are knowledgeable about the legislative requirements associated with:

1) the promotion of zero tolerance of abuse and neglect of residents;

2) the reporting of abuse and neglect of a resident to the Director under the Long-Term Care Homes Act, 2007;

3) the investigation of and responses for an alleged or suspected incident of abuse or neglect of a resident; and

4) the duty to protect residents from abuse.

All steps taken in response to this order must be fully documented, along with an analysis of the impact of the corrective actions and the measures implemented if knowledge deficits are identified following the implementation of the corrective actions.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #008 was protected from abuse by PCA #113 in the home.

This inspection is related to log #013069-18.

On a specified date, the Licensee reported an alleged, suspected incident of staff to resident emotional abuse. The Critical incident report submitted indicated the incident occurred on a specified date whereby PCA #113 was emotionally abusive towards resident #008.

Resident #008 reported to inspector #547 after this incident of feeling intimidated, ignored and pushed around by PCA #113 during the resident's personal care provision before the supper meal. Resident #008 indicated having reported this concern to PCA #107 who then reported it to RPN #105 that evening.

PCA #107 indicated to inspector #547 during an interview, that resident #008's call bell cord was observed on the floor upon entering the resident's room before the supper meal on this specified date of the incident. PCA #107 indicated finding the location of the call bell cord odd as resident #008 is alert and oriented and can direct the PCA staff for personal care needs and preferences. Resident #008 reported to PCA #107 of being abused by PCA #113. PCA #107 reported this to RPN #105 immediately.

RPN #105 indicated to inspector #547 to have been made aware of an incident between PCA #113 and resident #008 on the date of the incident. RPN #105 immediately interviewed resident #008 and called charge RN #109. RPN #105 further indicated PCA #113 was not a regular nursing staff in the home as contracted in from an agency.

RPN #105 indicated to inspector #547 that an agency PCA insisted that resident #008 stay in bed and would feed the resident in bed and then took away the resident's call bell. RPN #105 indicated going to see resident #008 who was lying in bed with a call bell attached and appeared to be very upset saying " agency PCA #113 was not listening to me and took my call bell away twice". RPN #105 indicated that resident #008 is alert and oriented and has never seen the resident so upset. RPN #105 reassured the resident and indicated that they would keep agency PCA #113 away from the resident for the rest of the evening. RPN #105 reported to inspector #547 that this was abusive behaviour towards resident #008 as over powering the resident and taking away the resident's

method to communicate to other staff in the home. RPN #105 indicated this incident was reported as per their internal procedures to the charge RN #109 and RPN #108 immediately.

Interviews were conducted with RN #109 and RPN #108 as charge staff in the home that evening by inspector #547. Both registered nursing staff members indicated to inspector #547 that they were aware that an incident between an agency staff member and a resident occurred on the unit as reported to them by RPN #105, however they did not immediately report this to the After Hours Manager, to the Administrator/Director of Care, or to the Director under the Long-Term Care Home's Act as required.

RN #109, RPN #108 or RPN #105 did not comply with the home's policy and procedure for Zero Tolerance of Resident Abuse and Neglect regarding this incident of alleged suspected resident abuse.

The incident was not investigated until two days after the incident occurred.

The appropriate police force was not informed until 19 days after the incident occurred.

Charge RN #109 and agency PCA #113 were not trained on the Licensee's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities with resident #008 on the date of the incident.

RPN #108 and Charge RN #109 had agency PCA #113 removed from resident #008's care duties after being made aware of this incident, but agency PCA #113 continued to work with residents in the home for the remainder of the evening shift on the date of the incident and returned to work with resident's in the home for the evening shift the following day. An incident occurred between agency PCA #113 and PCA #107 on the evening shift of the following day. PCA #107 reported to the evening Charge RN #119 that agency PCA #113 threatened PCA #107 for reporting the emotional abuse incident between agency PCA #113 and resident #008 the evening prior. RN #119 reported this concern to the After Hours Manager for the home, who removed agency PCA #113 from the home.

No investigation to the incident of resident #008 from the date of the incident occurred until the Administrator/Director of Care was made aware of the allegation of resident abuse two days later from reading an email from the After Hours Manager related to the threats made to PCA #107. Once the Administrator/Director of Care reviewed the allegations of the incident of staff to staff threat, was when the Administrator/Director of Care realized the staff to resident abuse that occurred in the home was not investigated or reported as required.

Thus, the issuance of Written Notification (WN) #3 ,#4, #5, #6, #8 and #9, as well as the severity of this issue was determined to be level 3 as there was actual harm to resident #008 related to emotional abuse. The scope of the issue was level 1 as there was one resident involved in this incident. The home has a level 2 history as they have 1 or more unrelated issues in last 36 months. The home has history of the issues linked to this order with Voluntary Plans of Correction (VPC) for LTCH Act 2007, c.8, s.20, s.23 and s.24 with inspections conducted over the last 36 months. (547)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of September, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Lisa Kluke

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