Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2016;	2016_320612_0018 (A1)	004007-16, 007627-16, 009453-16, 009501-16, 011660-16, 011796-16, 016930-16	Complaint

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Home requested an extension for compliance order #002 from November 3, 2016, to November 17, 2016.

Issued on this 31 day of October 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 20-23, 2016.

This Complaint Inspection is related to two complaints alleging abuse towards residents, two complaints related to care not being provided to residents, one complaint related to not following the resident's plan of care, one complaint related to residents rights and one complaint related to the Director of Care (DOC) not being on site.

A Follow Up Inspection #2016_320612_0017 and Critical Incident (CI) Inspection #2016_320612_0019 were conducted concurrently during this inspection. The following findings of non-compliance from CI Inspection #2016_320612_0019 were issued in this report under LTCHA, 2007 s. 19. (1)., s. 20. (1)., s. 23. (1). (a)., s. 23. (2)., and s. 24. (1).

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nutrition and Food Services Supervisor, Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant, Activation Coordinator, Education Coordinator, Housekeeper, Payroll worker, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions,

reviewed residents' health care records, staff training records, policies, procedures, programs, and staff personnel files.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

The Long-Term Care Homes Act, 2007, defines sexual abuse as any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Inspector #603 interviewed the complainant who explained that after the incident resident #007 became fearful. On a daily basis, resident #007 observed resident #001 in specific areas of the home. The complainant requested a certain intervention be implemented, however, a different intervention was implemented. Resident #007 did not like the intervention that was implemented.

Inspector #603 interviewed RN #103 who explained that resident #001 was known for displaying sexual behaviours but would normally direct these behaviours towards staff. An external resource had been involved with resident #001 due to their sexually inappropriate behaviours with staff and with resident #007. RN #103 also explained that the nursing staff had suggested the same intervention as the complainant, however, it was not approved and a different intervention was implemented. No attempts were made to address situations when resident #007 and #001 were within close proximity of each other.

Inspector #603 interviewed Supervisor #102. They explained that they were approached by the complainant who wanted a certain intervention implemented. When the Supervisor approached the Administrator about this request, they were given direction not to implement the requested intervention because the allegations of the incident on the specific date were unproven and that this was a one-time event. The Supervisor explained that normally, the home would do it's best to implement certain interventions. In this case, resident #007 was not protected from resident #001.

Inspector #603 interviewed the Administrator who explained that the specific intervention was not implemented.

During another interview with the Administrator, Inspector #603 asked if the home had reported the incident of resident to resident abuse from resident #001 towards resident #007 on the specific date. The Administrator explained that the home did not report the incident to the Director because they did not feel that sexual abuse

or any type of abuse had occurred between the two residents.

Inspector #603 reviewed resident #007's progress notes which indicated that the resident had reported the incident of resident to resident abuse on the specific date. The progress note referred to resident #001 as the abuser and that they had a history of exhibiting inappropriate sexual behaviours. Progress notes three days after the incident indicated that resident #007 continued to be fearful of resident #001.

Inspector #603 reviewed resident #001's health care record which revealed a specific referral to an external resource. The reason for referral indicated: Sexually inappropriate behaviours with staff and one incident with another resident.

Inspector #603 reviewed resident #001's care plan which had no mention of sexually inappropriate behaviours or as identified in the referral to the external resource.

A review of the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date, indicated that "Persons having reasonable grounds to suspect abuse or neglect had occurred had an obligation to report it to the administration immediately. All reported incidents shall be investigated".

According to the LTCHA, 2007, s. 23. (1) (a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. The incident of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, was not investigated.

According to the LTCHA, 2007, s. 23. (1) (b), every licensee of a long-term care home shall ensure that, appropriate action is taken in response to every such incident. The incident of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, made resident #007 very fearful. A certain intervention was requested, however, it was denied and no appropriate action was taken in response to this incident.

According to the LTCHA, 2007, s.24 (1), a person who has reasonable grounds to suspect that 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, immediately report the suspicion and the information upon with it is based to the Director. The incident

of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, was not reported to the Director.

According to the O. Reg. 79/10, s. 76. (2) 3, every licensee shall ensure that no staff performs their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The Administrator and the DOC did not receive training in the home's policy to promote zero tolerance of abuse and neglect of residents before their start date in December 2015 (Administrator) and April 2016 (DOC).

According to the O. Reg. 79/10, s. 76. (4), every licensee shall ensure that the persons who have received training on the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, shall receive retraining annually. According to the home's training stats for 2015, 63 per cent of active staff had not completed their annual training or retraining.

During further review of the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date, by Inspector #603, it failed to contain the following required information as pursuant to the LTCHA, 2007, s. 20 (2):

(c) Provided for a program, that complied with the regulations, for preventing abuse and neglect;
(e) Contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) Set out the consequences for those who abuse or neglect residents;
(g) Complied with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

The following requirements were also missing in accordance to O. Reg. 79/10, s. 96.:

a) Procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
b) Procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
c) Identification of measures and strategies to prevent abuse and neglect;
d) Identification of 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) Identification of the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations.

The DOC and Administrator were interviewed on June 22, 2016, at 1000 hours and they confirmed that the above required information was missing from the home's abuse policy. [s. 19. (1)]

2. Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in July 2015. The CI indicated that on a specific date, RPN #113 was in an area of the home and witnessed resident #016 push resident #015. Resident #016 denied hitting resident #015. Resident #015 had sustained multiple injuries. A head injury routine was initiated and the staff frequently monitored resident #015's whereabouts.

The Inspector reviewed resident #015's care plan utilized at the time of the incident, which revealed a specific intervention related to a specific responsive behaviour.

The Inspector reviewed resident #016's care plan utilized at the time of the incident. The care plan revealed numerous specific interventions related to resident #016's physical behaviours.

The Inspector reviewed resident #016's progress notes which indicated there was a second incident involving resident #015 that occurred on the same date as the previous incident. According to the progress notes, no staff intervened during the incident.

The Long-Term Care Homes Act, 2007, defines physical abuse, the use of physical force by a resident that causes physical injury to another resident.

In this case, the home failed to protect resident #015 from resident #016 when they knew resident #016 exhibited specific behaviours. The home also failed to remove resident #016 from situations which could have provoked them. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:
(c) provided for a program, that complied with the regulations, for preventing abuse and neglect
(e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents
(f) set out the consequences for those who abuse or neglect residents
(g) complied with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

Inspector #603 reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date. The contents of the policy did not include the following:
1) A program, that complies with the regulations, for preventing abuse and neglect, which included the following:
a) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
b) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
c) identification of measures and strategies to prevent abuse and neglect;
d) identification of 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) identification of the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations.
2) Procedures for investigation and responding to alleged, suspected or witnessed abuse and neglect of residents;
3) Consequences for those who abuse or neglect residents.

Inspector #603 interviewed the Administrator and the DOC and reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy" with them. The Administrator and the DOC confirmed that the home's "Abuse and Neglect Zero Tolerance Policy" did not provide the above information. [s. 20. (2)]

Additional Required Actions:

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

Inspector #603 reviewed a complaint submitted to the Director in February 2016. The complainant indicated that resident #009 had a specific item, stored in a specific area of the home. Earlier this year, the Administrator had instructed a staff member to dispose of the specific item. When the resident found out about it, they were upset.

The Inspector interviewed resident #009 who explained that the home had disposed of the specific item. The resident was told by a staff member that the home had lent the specific item to another facility, however, the resident later found out that the specific item had been disposed of without their permission. The resident was upset and felt that the disposal of the specific item without their permission was unfair.

The Inspector interviewed the staff member who explained that the Administrator had requested a certain area of the home be "cleaned up" and therefore they had disposed of resident #009's specific item. When the resident asked about the specific item, the staff member explained that they had sent the specific item to another facility, however, the staff member felt guilty for having lied to the resident and they told the resident that the specific item had actually been disposed of.

The Inspector interviewed the Administrator who explained that there was a miscommunication with the staff member regarding the specific item. The Administrator assumed that the resident and their family would have been consulted prior to removing the specific item from an area of the home. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #009 is treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated: (i) Abuse of a resident by anyone.

Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

Inspector #603 reviewed resident #007’s progress notes which indicated that the resident had reported the incident of resident to resident abuse on the same specific date.

Inspector #603 interviewed RN #103 who explained that the nursing staff had reported to administration the alleged resident to resident abuse from resident #001 towards resident #007 on the same specific date.

Inspector #603 interviewed the Administrator who explained that the home did not report the incident to the Director or investigate the incident because they did not feel that sexual abuse or any type of abuse had occurred between the two residents. The Administrator explained that resident #001 had simply entered resident #007’s room and touched the resident.

Inspector #603 reviewed the home’s policy titled, “Abuse and Neglect Zero Tolerance Policy,” with no previous review date, which indicated that "all reported incidents shall be investigated”. [s. 23. (1) (a)]

2. Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in July 2015. The CI indicated that on a specific date, RPN #113 was in an area of the home and witnessed resident #016 push resident #015. Resident #016 denied hitting resident #015. Resident #015 had sustained multiple injuries. A head injury routine was initiated and the staff frequently monitored resident #015's whereabouts.

Inspector #612 requested the investigation notes for the CI report, however, there were no investigation notes available.

Inspector #603 reviewed the home’s policy titled, “Abuse and Neglect Zero Tolerance Policy,” with no previous review date, which indicated that "all reported incidents shall be investigated”. [s. 23. (1) (a) (i)]

3. Inspector #603 reviewed a CI report, submitted by the home to the Director in August 2014. The CI indicated that resident #014 was inappropriately touched by resident #012.

The CI was filed by a previous Administrator in the home as "Inappropriate touching". As a result of the incident, resident #014 was referred to an external

resource for assessment of their behaviours as they were identified as an ongoing issue within the home.

Inspector #612 requested the home's investigation notes for this incident and the DOC was not able to find any information and could not confirm that an investigation had been completed.

Inspector #603 reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous review date, which indicated that "all reported incidents shall be investigated". [s. 23. (1) (a) (i)]

4. The licensee has failed to ensure that appropriate action was taken in response to every such incident.

Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

Inspector #603 interviewed RN #103 who explained that resident #001 was known for displaying sexual behaviours but would normally direct these behaviours towards staff. An external resource had been involved with resident #001 due to their sexually inappropriate behaviours with staff and with resident #007. RN #103 also explained that the nursing staff had suggested the same intervention as the complainant, however, it was not approved and a different intervention was implemented. No attempts were made to address situations when resident #007 and #001 were within close proximity of each other.

Inspector #603 interviewed the complainant who explained that they requested a specific intervention, however, a different intervention was implemented. Resident #007 did not like the intervention that was implemented.

Inspector #603 interviewed Supervisor #102. They explained that they were approached by the complainant who wanted a certain intervention implemented. When the Supervisor approached the Administrator about this request, they were given direction not to implement the requested intervention because the allegations of the incident on the specific date were unproven and that this was a one-time event. The Supervisor explained that normally, the home would do it's best to implement certain interventions. In this case, resident #007 was not protected from resident #001.

Inspector #603 interviewed the Administrator who explained that the specific intervention requested by the complainant and resident #007 was not implemented and that another intervention was implemented. [s. 23. (1) (b)]

5. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Inspector #612 reviewed a CI report which alleged abuse by RPN #112 towards resident #013. The CI indicated that Housekeeper #111 witnessed RPN #112 emotionally abuse resident #013.

The Inspector interviewed the current DOC who stated that they provided all the investigation notes to the Inspector however was unable to comment on the outcome of the investigation, as they were not here at the time of the incident.

The Inspector interviewed Housekeeper #111 who confirmed that they had witnessed and reported the incident, however they were unable to comment on the outcome as they were never informed of the outcome. [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, specifically, but not limited to abuse of a resident by anyone and that appropriate action is taken in response to every incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

Inspector #603 reviewed resident #007's progress notes which indicated that the resident had reported the incident of resident to resident abuse on the specific date. The progress note referred to resident #001 as the abuser and that they had a history of exhibiting inappropriate sexual behaviours. Progress notes three days after the incident indicated that resident #007 continued to be fearful of resident #001.

Inspector #603 interviewed the RN #103 who explained that the nursing staff had reported to administration the alleged resident to resident abuse from resident #001 towards resident #007 on the specific date.

Inspector #603 interviewed the Administrator and asked if the home had reported the incident of resident to resident abuse from resident #001 towards resident #007 on the specific date. The Administrator explained that the home did not report the incident to the Director because they did not feel that sexual abuse or any type of abuse had occurred between the two residents.

Inspector #603 reviewed the home's policy titled, "Reporting Certain Matters to the MOHLTC Policy," with no previous review date, which indicated that "The administration for Director of Resident Care or designate will ensure all appropriate issues are reported to the MOHLTC as set out in Appendix A- Mandatory reporting to the Director". This included "abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or as risk of harm to the resident". [s. 24. (1)]

2. Inspector #612 reviewed a CI report which alleged abuse by RPN #112 towards resident #013. The CI indicated that Housekeeper #111 witnessed RPN #112 emotionally abuse resident #013. Housekeeper #111 reported the incident immediately to a previous Director of Care.

The Inspector interviewed Housekeeper #111 who confirmed that they immediately reported the incident after they witnessed it to the DOC at the time. They reported that no one followed up with them in regards to the investigation or outcome.

The Inspector reviewed the investigation notes provided by the home which did not indicate why the Director was not notified until almost six months after the incident.

The current DOC was unable to provide any comment in regards to this incident as they were not employed by the home when the incident had occurred. [s. 24. (1) 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 the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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 staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

Inspector interviewed the Administrator who explained that the incident on the specific date, between resident #001 and #007 was not reported to the Director because the home did not feel that sexual abuse or any type of abuse had occurred between the two residents.

Inspector reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous review date, which revealed that:
1. All staff must receive training on hire and annually thereafter on the Resident's Bill of Rights including the power imbalance between staff and residents and the potential for abuse and neglect by those in a position of power and responsibility for resident care.
2. All staff must receive training on Mandatory Reporting requirements on hire and annually thereafter.
3. All staff must receive training on Whistle Blower Protection policy on hire and annually thereafter.
4. All staff must receive training on Responsive Behaviours policy and procedure, Gentle Persuasive Approach and Non Violent Crisis intervention in prevention of abuse.

A review of the home's education tracking document titled, "LTC Mandatory - All Staff - Training for the Zero Tolerance for Abuse and Neglect Policy" revealed that the Administrator and the DOC had not received this training on hiring. The Administrator was hired in December 2015, and the DOC was hired April 2016.

The Inspector interviewed the Education Coordinator who confirmed that all staff including the Administrator and the DOC were to receive training on the "Zero Tolerance for Abuse and Neglect Policy" on hiring, which they did not. [s. 76. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, specifically the Administrator and DOC, prior to performing their responsibilities, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for the following amount of time per week: 5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

A complaint was received by the Director stating that there was a period of time in March, 2016, where there was no DOC on site in the home.

Inspector #612 spoke with a staff member #119 in Human Resources and they stated that as per their records, the previous DOC #120's last day on site was March 11, 2016 and their final day of employment was March 21, 2016.

In an interview with the Administrator and an acting DOC #121 from an affiliated home, they were able to confirm coverage by a DOC on site after March 21, 2016. The Administrator provided the Inspector with email correspondence between the Administrator and the previous DOC #120 which stated that DOC #120 was off site on vacation but would be available by phone between March 11, 2016 and March 21, 2016 should they need to be contacted. [s. 213. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home, in a home with a licensee bed capacity of 65 beds or more, at least 35 hours per week, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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 was provided to the resident as specified in the plan of care.

Inspector #612 reviewed a complaint received by the Director which stated that resident #003, was signed out on a specific date and time by someone other than the Power of Attorney (POA). The residents POA was not notified until a specific amount of time later. The home filed a CI report in relation to this incident.

The Inspector interviewed RPN #116 and PSW #117 who stated that they were aware that the resident was not to have visitors or leave the facility unless they were with the POA as indicated in resident #003's plan of care.

The Inspector interviewed RN #105. They stated that there were specific interventions identified in the resident's plan of care regarding who was to visit and who the resident could leave the home with and that staff should follow the specific interventions in the plan of care.

No further action will be taken in regards to this non-compliance as there is currently an outstanding order for s. 6. (7). in Critical Incident Report #2016_339617_0021. [s. 6. (7)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report to the Director included analysis and follow- up action, including: ii) the long-term actions planned to correct the situation and prevent recurrence.

The home filed a CI report, regarding resident #003 who was signed out of the home on a specific date and had not returned for a specific period of time. The CI report indicated that the resident was signed out by another family member on a sign out sheet but the sheet did not indicate a time of return and did not include the signature of the person who signed the resident out.

The Inspector reviewed the CI report on June 20, 2016, which indicated that the long-term actions to correct this situation and prevent recurrence were to "follow-up". The Director had requested an update with the long-term actions on a specific date in May 2016, however the CI was never amended by the home.

The Inspector interviewed the Administrator who stated that the home had actually reviewed their sign out sheet and were now including a spot for the person who was signing out the resident to print their name so that staff would be able to identify who had signed the resident out. They were unable to tell the inspector why the CI was not updated to reflect the long-term actions planned to correct the situation and prevent recurrence. [s. 107. (4) 4.]

Issued on this 31 day of October 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2016_320612_0018 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004007-16, 007627-16, 009453-16, 009501-16, 011660-16, 011796-16, 016930-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Oct 31, 2016;(A1)

Licensee / Titulaire de permis : RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7

LTC Home / Foyer de SLD : RAINYCREST
550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Emily Bosma

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To RIVERSIDE HEALTH CARE FACILITIES, INC., 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. 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:

a) Ensure that all residents in the home are protected from abuse by anyone and not neglected by the licensee or staff.

b) Review, revise and update resident #016's care plan to ensure that the interventions are effective to protect other residents from abuse by resident #016.

c) Update and implement resident #015's care plan to ensure that they are protected from abuse by resident #016.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in July 2015. The CI indicated that on a specific date, RPN #113 was in an area of the home and witnessed resident #016 push resident #015. Resident #016 denied hitting resident #015. Resident #015 had sustained multiple injuries. A head injury routine was initiated and the staff frequently monitored resident #015's whereabouts.

The Inspector reviewed resident #015's care plan utilized at the time of the incident, which revealed a specific intervention related to a specific responsive behaviour.

The Inspector reviewed resident #016's care plan utilized at the time of the incident. The care plan revealed numerous specific interventions related to resident #016's physical behaviours.

The Inspector reviewed resident #016's progress notes which indicated there was a second incident involving resident #015 that occurred on the same date as the previous incident. According to the progress notes, no staff intervened during the incident.

The Long-Term Care Homes Act, 2007, defines physical abuse, the use of physical force by a resident that causes physical injury to another resident.

In this case, the home failed to protect resident #015 from resident #016 when they knew resident #016 exhibited specific behaviours. The home also failed to remove resident #016 from situations which could have provoked them. (612)

2. Inspector #603 reviewed a complaint submitted to the Director in April, 2016. The complainant alleged resident #007 sexually abused resident #001 during an altercation. This incident made resident #007 fearful of resident #001.

The Long-Term Care Homes Act, 2007, defines sexual abuse as any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Inspector #603 interviewed the complainant who explained that after the incident resident #007 became fearful. On a daily basis, resident #007 observed resident #001 in specific areas of the home. The complainant requested a certain intervention be implemented, however, a different intervention was implemented. Resident #007 did not like the intervention that was implemented.

Inspector #603 interviewed RN #103 who explained that resident #001 was known for displaying sexual behaviours but would normally direct these behaviours towards staff. An external resource had been involved with resident #001 due to their sexually inappropriate behaviours with staff and with resident #007. RN #103 also explained that the nursing staff had suggested the same intervention as the complainant, however, it was not approved and a different intervention was implemented. No attempts were made to address situations when resident #007 and #001 were within close proximity of each other.

Inspector #603 interviewed Supervisor #102. They explained that they were approached by the complainant who wanted a certain intervention implemented. When the Supervisor approached the Administrator about this request, they were given direction not to implement the requested intervention because the allegations of the incident on the specific date were unproven and that this was a one-time event. The Supervisor explained that normally, the home would do it's best to implement certain interventions. In this case, resident #007 was not protected from resident #001.

Inspector #603 interviewed the Administrator who explained that the specific intervention was not implemented.

During another interview with the Administrator, Inspector #603 asked if the home had reported the incident of resident to resident abuse from resident #001 towards resident #007 on the specific date. The Administrator explained that the home did not report the incident to the Director because they did not feel that sexual abuse or any type of abuse had occurred between the two residents.

Inspector #603 reviewed resident #007's progress notes which indicated that the resident had reported the incident of resident to resident abuse on the specific date. The progress note referred to resident #001 as the abuser and that they had a history of exhibiting inappropriate sexual behaviours. Progress notes three days after

the incident indicated that resident #007 continued to be fearful of resident #001.

Inspector #603 reviewed resident #001's health care record which revealed a specific referral to an external resource. The reason for referral indicated: Sexually inappropriate behaviours with staff and one incident with another resident.

Inspector #603 reviewed resident #001's care plan which had no mention of sexually inappropriate behaviours or as identified in the referral to the external resource.

A review of the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date, indicated that "Persons having reasonable grounds to suspect abuse or neglect had occurred had an obligation to report it to the administration immediately. All reported incidents shall be investigated".

According to the LTCHA, 2007, s. 23. (1) (a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. The incident of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, was not investigated.

According to the LTCHA, 2007, s. 23. (1) (b), every licensee of a long-term care home shall ensure that, appropriate action is taken in response to every such incident. The incident of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, made resident #007 very fearful. A certain intervention was requested, however, it was denied and no appropriate action was taken in response to this incident.

According to the LTCHA, 2007, s.24 (1), a person who has reasonable grounds to suspect that 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, immediately report the suspicion and the information upon with it is based to the Director. The incident of alleged resident to resident abuse involving resident #001 toward resident #007 in April 2016, was not reported to the Director.

According to the O. Reg. 79/10, s. 76. (2) 3, every licensee shall ensure that no staff performs their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The Administrator and the DOC did not receive training in the home's policy to promote

zero tolerance of abuse and neglect of residents before their start date in December 2015 (Administrator) and April 2016 (DOC).

According to the O. Reg. 79/10, s. 76. (4), every licensee shall ensure that the persons who have received training on the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, shall receive retraining annually. According to the home's training stats for 2015, 63 per cent of active staff had not completed their annual training or retraining.

During further review of the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date, by Inspector #603, it failed to contain the following required information as pursuant to the LTCHA, 2007, s. 20 (2):

(c) Provided for a program, that complied with the regulations, for preventing abuse and neglect;
(e) Contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) Set out the consequences for those who abuse or neglect residents;
(g) Complied with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

The following requirements were also missing in accordance to O. Reg. 79/10, s. 96.:

a) Procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
b) Procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
c) Identification of measures and strategies to prevent abuse and neglect;
d) Identification of 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) Identification of the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations.

The DOC and Administrator were interviewed on June 22, 2016, at 1000 hours and they confirmed that the above required information was missing from the home's abuse policy.

There was a previous compliance order issued during complaint inspection #2014_380593_0007.

The decision to issue this compliance order is based on the previous compliance history, the severity, which was actual harm to resident #007 and the scope, which was isolated. (603)

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

Nov 03, 2016

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;

(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) shall set out the consequences for those who abuse or neglect residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall:

1. Undertake a comprehensive review of the Home's policies to promote zero tolerance of abuse and neglect of residents, and make revisions in order to ensure compliance with all elements of the legislative and regulatory requirements.

2. This review and revision shall include, but not be limited to, the following:

a) a clear description of the Home's process with clear timelines to ensure that "a person" (i.e. anyone) who has reasonable grounds to suspect any of the mandatory reporting elements have occurred reports the matter to the Director (under the LTCHA);

b) procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, including who will undertake the investigation and who will be informed of the investigation;

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

d) set out the consequences for those who abuse or neglect residents;

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

f) identification of measures and strategies to prevent abuse and neglect; and

g) identification of the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations.

3. Ensure that all staff are provided with education and training on the revised policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:
(c) provided for a program, that complied with the regulations, for preventing abuse and neglect
(e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents
(f) set out the consequences for those who abuse or neglect residents
(g) complied with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

Inspector #603 reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy," with no previous revision date. The contents of the policy did not include the following:
1) A program, that complies with the regulations, for preventing abuse and neglect, which included the following:
a) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
b) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
c) identification of measures and strategies to prevent abuse and neglect;
d) identification of 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) identification of the training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations.
2) Procedures for investigation and responding to alleged, suspected or witnessed abuse and neglect of residents;
3) Consequences for those who abuse or neglect residents.

Inspector #603 interviewed the Administrator and the DOC and reviewed the home's policy titled, "Abuse and Neglect Zero Tolerance Policy" with them. The Administrator and the DOC confirmed that the home's "Abuse and Neglect Zero Tolerance Policy" did not provide the above information.

There is no previous history of related non-compliance.

The decision to issue this compliance order was due to the actual harm/risk and the scope which was widespread as it is a policy that affects all residents and staff. (603)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Nov 17, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail 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 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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 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
Inspection 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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.

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
Inspection 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

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 31 day of October 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury