Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2019	2018_578672_0010 (A1)	008844-18	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Terraces
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

Amended by CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Changes to the report related to educational requirements for Compliance Order #004, have been removed at the licensee's request, following meeting with MOHLTC managers.

Issued on this 15th day of January, 2019 (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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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Amended by CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 25, 28-31, June 1, 4 -8, 2018

The following Critical Incident Report (CIR) intakes were completed during the Critical Incident inspection:

Log #008844-18 - Related to an alleged incident of resident to resident physical abuse, which resulted in the death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician(s), Coroner, Resident Care Coordinator(s) (RCC), RAI Coordinator, Registered Dieticians (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support Ontario Registered Practical Nurse (BSO RPN), Personal Support Workers (PSW), Dietary Aides (DA), residents and family members.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

7 WN(s)
2 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident Report (CIR) was submitted to the Director, regarding an incident of resident to resident physical abuse, which occurred on a specified date, between resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain, and was diagnosed with an injury. Resident #002 returned to the home on a specified date, and passed away in the home on a later specified date, due to complications of the injury sustained during the incident.

Inspector #672 reviewed the Physician's Orders and Medication Administration Record for a specified month related to resident #002, which indicated that resident had an order for a pain medication.

Inspector #672 then reviewed the progress notes for resident #002, for a specified time period, until resident #002 passed away. Review of the progress notes indicated the following:

On a specified date, on all three shifts, resident #002 was noted to have symptoms of pain observed. According to the progress notes, resident #002 received a pain medication on the night shift, with poor effect, and another pain medication on the day shift, with poor effect. There was no documentation the Physician was informed of the resident's pain control.

On a specified date, during the night shift, resident #002 was noted to have signs of pain observed. Resident #002 received a pain medication, with fair effect, as

resident only slept intermittently. During the day shift, resident received a pain medication at the beginning of the shift, with poor effect, as resident was noted to have signs of pain observed. There was no documentation available from the evening shift. The documentation did not indicate that the Physician was informed of the resident's poor pain control.

On a specified date, resident was observed to be in pain, and received a pain medication with fair effect, as resident only slept intermittently. During the day shift, resident received a pain medication with poor effect, as resident continued to be observed to have "obvious pain and discomfort". Resident continued to have observed pain on the evening shift, as per documentation. There was no documentation to state the Physician was informed of the resident's poor pain control.

On a specified date, resident was noted to be in severe pain, and was no longer able to take any pain medications by mouth. The RN called the Physician, and left a message at a specified time, to inform of resident #002's severe pain, and inability to swallow the pain medication, which had resulted in resident #002 not having any pain relief in greater than fifteen hours. There was no documentation that the Physician returned the phone call, and no new orders were received. Documentation indicated that this information was passed along to the evening RN. During the evening shift, resident #002 sustained another fall. Resident was observed to be in pain when assessed. Documentation in the progress notes further indicated that resident #002 would be assessed by the Physician during the Physician's "next rounds", and there was no documentation to support that the Physician had been contacted directly, to be informed of the fall, or resident #002's severe pain, and inability to swallow pain medications, which lead to the resident not having received any pain medication at that point in greater than 24hrs.

Inspector #672 reviewed the MAR for a specified month related to resident #002, and observed that resident #002 had not received any pain medication since a specified date and time.

During separate interviews, RN #105, RN #125, and RPN #106 indicated that they cared for resident #002 for several shifts during a specified period of time. RN #105, RPN #106, and RN #125 indicated that resident #002 appeared to be in severe pain during those shifts, but the Physician had not been notified, and resident #002's plan of care had not been reviewed and revised.

During an interview, RN #122 indicated an attempt had been made to contact the Physician on a specified date, to report that resident #002 appeared to be in severe pain, and was no longer able to take oral pain medication, but had to leave a voice message. RN #122 further indicated that another Physician had not been contacted when the primary Physician could not be reached, and had forwarded the concerns to the oncoming RN to follow up with.

During an interview, RPN #133 indicated that a specified date was the first shift working with resident #002 since the resident's return from hospital with the injury, and it had been obvious that resident #002 was in significant pain. RPN #133 contacted Physician #112, and secured an order to discontinue the oral pain medications, and initiate pain medications via injection, which was initiated in the early afternoon of a specified date.

During an interview, Physician #112 indicated staff had not brought forward concerns regarding resident #002's pain control until the morning of a specified date. Once Physician #112 became aware of resident #002's poor pain control, an order was immediately provided to discontinue the oral pain medications, and ordered pain medication via injection, which was implemented on a specified date and time.

During an interview, RCC #102 indicated that the expectation in the home was that if a resident's condition changed, and/or if the resident appeared to be in pain, or was no longer able to swallow oral medications, the registered staff should contact the Physician responsible for that resident immediately, to secure new orders. RCC #102 further indicated that if the responsible Physician could not be reached, there were multiple other Physician's employed by the home who should be contacted to secure an order for the resident.

The licensee failed to ensure that resident #002 was reassessed, and the plan of care reviewed and revised when the resident's pain was not controlled over a four day period; or when the resident was no longer able to swallow oral medications, which lead to resident #002 not receiving any pain medication for over 39 hours, despite being observed to be in severe pain. [s. 6. (10) (b)]

2. The licensee has failed to ensure that the written plan of care for resident #001 was reassessed when the resident's care needs changed, and the care set out in the plan changed.

A Critical Incident Report was submitted to the Director, to report an alleged incident of resident to resident physical abuse between resident #001 and #002. The incident resulted in an injury to resident #002, which required hospitalization.

On a specified date, as a result of the resident to resident physical abuse incident, a specified intervention and assessment were implemented for resident #001.

On a specified date, a specified intervention was initiated on the night shift. On a later specified date, the same specified intervention was initiated on all three shifts. The written plan of care for resident #001 was not updated until two later dates, for the identified changes.

The specified assessment for a specified period of time identified a number of incidents where resident #001 was noted to exhibit specified responsive behaviours. The written plan of care did not identify any changes until a later date.

The licensee failed to ensure that the written plan of care for resident #001 was reassessed when the resident's care needs changed, and the care set out in the plan changed, related to specified interventions and assessments related to management of identified responsive behaviours for resident #001.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) Resident #002's plan of care specific to pain control was not reviewed and revised when their care needs changed.

2) A VPN was issued during a Resident Quality Inspection (#2015_360111_0019) on September 14, 2015, under LTCHA, 2007, s.6. A VPC was then reissued during a Complaint inspection on January 19, 2018, under LTCHA, 2007, s.6. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 #002 was protected from abuse by anyone in the home.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

"emotional abuse" means, (a) 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 residents.

"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

A Critical Incident Report was submitted to the Director regarding an incident of resident to resident physical abuse, which occurred on a specified date, between resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain, and the resident was diagnosed with an injury. Resident #002 returned to the home on a specified date, and the resident passed away in the home on a later specified date, due to complications related to the injury sustained during the incident with resident #001.

During a record review, resident #001's clinical health records and progress notes were reviewed during a specified time period, which revealed that resident #001 exhibited responsive behaviours, which had resulted in multiple incidents of verbal and physical behaviours directed towards staff and other residents in the home.

Resident #002's clinical health records and progress notes were reviewed during a specified time period, which revealed that resident #002 exhibited responsive behaviours.

During separate interviews, PSWs #108, #110, #111, and #113 indicated that resident #001 was known to have unpredictable responsive behaviours, which required a lot of redirection from the staff, which was not always effective. PSW #111 indicated that resident #001 and #002 had a history with each other, and that resident #002 "seemed to set off" resident #001. PSWs #108, #110, #111, and #113 further indicated that resident #001 was not receiving a specific intervention, or further interventions other than the redirection.

During an interview, RN #105 indicated that resident #001 exhibited specified responsive behaviours, and had a history of identified responsive behaviours directed towards co-residents. RN #105 further indicated that resident #002 was known to exhibit specified responsive behaviours, which could result in verbal and physical behaviours, therefore staff tried to ensure that specified interventions were implemented, which was not always effective. RN #105 indicated that at the time of the incident between resident #001 and #002, there were several residents who resided on the home area who wandered, and staff could not supervise the residents at all times, due to being busy providing care to other residents, or being on break.

During an interview, BSO RPN #104 indicated that resident #001 had a history of exhibiting responsive behaviors. BSO RPN #104 further indicated that resident #001 had been previously discharged from the BSO program, due to a belief that the resident's behaviours had calmed down in the past two months.

Resident #001's progress notes were reviewed for a specified time period, which included documentation that between that time frame, resident #001 had been involved in five incidents of physical behaviours towards co-residents and staff, and some of the incidents had resulted in physical injuries.

During an interview, the DOC indicated being aware of resident #002 exhibiting

specified responsive behaviours, and requiring specified interventions. The DOC confirmed that resident #001 was not involved in the BSO program in the home and current interventions being implemented were appropriate to manage the resident's exhibited responsive behaviours.

The licensee failed to ensure that co-residents, including resident #002 was protected from incidents of emotional and physical abuse by resident #001, pursuant to s.19 of the LTCHA. as identified by the following:

- When resident #001 was exhibiting responsive behaviours, the licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident #001's exhibited responsive behaviours. The assessments completed for resident #001 related to responsive behaviour were incomplete and not evaluated to develop and implement interventions related to responsive behaviours for resident #001, as issued under WN #7 LTCHA r. 55 (1).

- When resident #002 was exhibiting responsive behaviours, the licensee failed to identify behavioural triggers for resident #002, to reassess the interventions listed within the written plan of care, and to document the resident's responses to the interventions, as issued under WN #6, LTCHA r. 53(4)(a).

- When resident #001's care needs changed, the licensee failed to ensure that the written plan of care for resident #001 was reassessed, and the care set out in the plan changed, related to the specified interventions and assessments completed, as issued under CO #001 , LTCHA s. 6. (10)(b).

- When the incident of resident to resident physical abuse occurred between resident #001 and #002, the licensee failed to ensure that the internal "Abuse and Neglect- Prevention, Reporting and Investigation Policy", ADM-01-03-05 dated November 20, 2017, was complied with, when statements related to an incident of resident to resident physical abuse were not dated and signed, and when the plan of care for resident #001 was not updated related to responsive behaviour interventions, as issued under WN #5, LTCHA s. 20 (1).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of

resident to resident abuse.

2) A WN was issued during a Resident Quality Inspection on September 14, 2015, under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident's responses to interventions were documented.

A Critical Incident Report was submitted to the Director, related to an incident of resident to resident physical abuse involving residents #001 and #002, which resulted in an injury to resident #002.

A review of resident #002's health records revealed that resident #002 had been exhibiting responsive behaviours prior to the incident with resident #001. A Resident's Assessment Instrument-Minimum Data Set (RAI-MDS) was completed on a specified date, with exhibited responsive behaviours noted.

A review of resident #002's progress notes for a specified period of time, related to responsive behaviours indicated:

On a specified date, RPN #106 completed a specified assessment of the resident's exhibited responsive behaviours. No update to the care plan identified.

On a specified date and time, resident #002 exhibited a responsive behaviour.

On a specified date and time, Physician #112 wrote a note regarding the resident's exhibited responsive behaviours.

On a specified date and time, RPN #106 wrote a note regarding the resident's exhibited responsive behaviours.

On a specified date and time, RPN #106 recorded an incident of exhibited responsive behaviours between resident #001 and #002.

On a specified date and time, RN #105 indicated on the falls assessment that the written plans of care for both residents related to responsive behaviours were to be reviewed. At a specified time, RN #105 wrote no goals for responsive behaviours were updated that day.

On a specified date and time, resident #002 remained in hospital with the injury sustained during the incident with resident #001.

A review of resident 002's written plan of care for responsive behaviours created on a specified date, and last revised on a specified date, identified exhibited responsive behaviours. The were identified interventions listed. The written plan of care for resident #002 neither identified behavioral triggers nor included new

interventions related to responsive behaviours.

In an interview, PSW #121 reported that resident #002 exhibited specified responsive behaviours. On a specified date, PSW #121 acknowledged that resident #002 did not require a specified intervention.

In separate interviews conducted by Inspector #461, PSW #134 and RPN #16, both indicated that resident #002 exhibited specified responsive behaviours. PSW #134 did not remember the resident having a specified intervention from the care plan implemented.

During an interview conducted by Inspectors #672 and #461, RN #125 reported that resident #002 exhibited specified responsive behaviours. RN #125 was unsure whether the resident had a specified intervention in place or not. Resident #002 had been involved with the Behavioural Support Ontario (BSO) program in the home in the past, but recently. RN #125 further reported that resident #002 had settled, hence a specified assessment or referral to the BSO program were not required.

In an interview conducted by Inspector #461, the DOC indicated being aware of resident #002 using a specified intervention, and exhibited specified responsive behaviours. The DOC confirmed that resident #002 was not involved in the BSO program in the home and current interventions being implemented were appropriate to manage the resident's exhibited responsive behaviours.

The licensee failed to identify behavioural triggers for resident #002, to reassess the interventions listed within the written plan of care, and to document the resident's responses to the interventions.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of resident to resident abuse.

2) A WN was issued during a Resident Quality Inspection on September 14, 2015, under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 53. (4) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm, or who were harmed, as a result of a resident's behaviours; and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident Report was submitted to the Director to report an incident of resident to resident physical abuse, which occurred between resident #001 and #002 on a specified date and time. The altercation resulted in an injury to resident #002.

Inspector #194 reviewed the licensee's "Responsive Behaviour Prevention and Management Program"; INTERD-03-09-01; dated January 13, 2015. The 2017

Annual Program Evaluation for Responsive Behaviours was completed to verify that the Responsive Behaviour Prevention and Management Program had been reviewed, and no changes were implemented.

The Responsive Behaviour Prevention and Management Program indicated:

- An interdisciplinary screening and assessment process using the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), the (P.I.E.C.E.S.) (Physical, intellectual, Emotional, Capacities, Environment, Social) Assessment Framework, and Behavioural Supports Ontario Assessment Tool (BAT) in conjunction with additional evidence-based practice assessments as required.

- Incidents of responsive behaviours in dementia will be documented appropriately and thoroughly in the resident's chart. This documentation will assist interdisciplinary staff to understand and identify key triggers related to challenging protective behaviours and successful interventions to manage and reduce these behaviours. Documentation will reflect a focus towards providing resident focused care designed to meet the needs of residents rather than problems to be managed.

A review of resident #001's progress notes related to specified exhibited responsive behaviours during a specified period of time was completed by Inspector #194 which indicated:

Responsive behaviours towards to co-residents;

- Between a specified period of time, there were a number of incidents of resident to resident exhibited responsive behaviours, resulting in no injury.

Responsive behaviours towards staff;

A review of the clinical health record for resident #001 for a specified period of time, indicated a number of documented incidents of exhibited responsive behaviours towards staff.

Specified assessments were initiated for resident #001's responsive behaviours. During separate interviews with RCC #102 and BSO RPN #104 it was verified that PSW staff would complete the specified assessment, and report the responsive behaviours to the Registered staff on the unit. The Registered staff

would then document the observed behaviours in the resident's clinical health record.

A review of the specified assessment during a specified time period, indicated no documentation recorded for nine identified shifts and four partial identified shifts. The documented behaviours on the assessment during this time period included specified exhibited responsive behaviours, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified time period, indicated no documentation recorded for four identified shifts and two partial identified shifts. The documented behaviours during this time period included specified exhibited responsive behaviours, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified period of time, indicated no documentation recorded for three identified shifts, and one partial identified shift. The documented behaviours during this time period included an exhibited responsive behaviour, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified time period indicated no documentation recorded for three identified shifts. The documented behaviours during this period included an exhibited responsive behaviour, with no supporting documentation in the progress notes.

During separate interviews conducted by Inspector #194 with DOC, RCC #102 and BSO RPN #104 there was no explanations provided related to the incomplete specified assessments or lack of documentation in the progress notes for resident #001, related to the responsive behaviours reported by the PSW staff on the specified assessment.

Review of the BSO RPN #104's documentation in resident #001's clinical health record, during specified periods of time, indicated that resident #001 continued to exhibit specified responsive behaviours, which were often not well received by co-residents.

A review of another specified assessment for resident #001, dated a specified date, was completed. A description of the identified behaviours was provided, along with the triggers identified and current interventions being implemented.

Review of the RAI-MDS assessments for resident #001 dated a specified date, indicated multiple exhibited responsive behaviours.

Review of the RAI-MDS assessments for resident #001 dated a specified date, indicated multiple exhibited responsive behaviours.

The behavioural symptoms interventions listed within the current written plan of care indicated five interventions.

Additional interventions within a specified written plan of care indicated five interventions.

Responsive behaviour care plan intervention indicated nine interventions.

A review of the behavioural plans of care for resident #001 were completed regularly by Registered staff, with no changes identified since admission to the home, with an exception of additional interventions documented on one specified date, approximately six months later.

Medication changes noted for resident #001 during a specified period of time, related to responsive behaviours included seven medication changes/adjustments.

Interviews with PSWs # 110, 111,113, 116, 119, and 120, RN #105, RPN #106, and BSO #104 indicated that resident #001's responsive behaviour could be unpredictable at times. The interviewed staff indicated that resident #001 could exhibit a specified responsive behaviour. Resident #001 exhibited a responsive behaviour, and redirection was utilized to manage the behaviour which was not well received by co-residents on the unit.

The licensee failed to ensure that procedures and interventions were developed and implemented related to resident #001's exhibited responsive behaviours. The assessments completed for resident #001 related to exhibited responsive behaviours were incomplete, and were not evaluated in order to develop and implement interventions related to the exhibited responsive behaviours of resident #001.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of resident to resident abuse.

2) The licensee had a compliance history with non-compliance in similar areas to r.55(a), as observed with a WN being issued during a Resident Quality Inspection on September 14, 2015, under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 55. (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the internal policy entitled "Pain Management Program"; Policy number INTERD-03-10-01; approved on December 15, 2015, was complied with.

In accordance with O. Reg. 79/10, r. 52. (2), the licensee was required to ensure that when a resident's pain was not relieved by initial interventions, the resident be assessed using a clinically appropriate assessment instrument specifically designed for that purpose; and in accordance with O. Reg 79/10, s. 6. (10) (b), the licensee was required to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident Report was submitted to the Director on a specified date, regarding an incident of resident to resident physical abuse, which occurred on a specified date, between resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain, and the resident received a diagnosis of an injury. Resident #002 returned to the home on a specified date, and passed away in the home approximately one week later, due to complications of the injury sustained during the incident with resident #001.

Inspector #672 reviewed the progress notes for resident #002 during a specified time frame, until resident #002 passed away. Review of the progress notes indicated the following:

Resident #002 returned from hospital on a specified date, after being in hospital for a specified time period. No pain assessment was observed to have been completed.

On a specified date, during all three shifts, resident #002 was noted to have symptoms of pain observed. According to the progress notes, resident #002 received breakthrough pain medication on the night shift with poor effect, and another pain medication on the day shift, with poor effect. No pain assessments were observed to have been completed.

On a specified date, during the night shift, resident #002 was noted to have non-verbal signs of pain observed. Resident #002 received pain medication, with fair effect, as the resident only slept intermittently. During the day shift, resident received pain medication at the beginning of the shift with poor effect, as resident was noted to have non-verbal signs of pain observed throughout the shift. No pain

assessment was observed to have been completed.

On a specified date, resident #002 was observed to be in pain and received pain medication with fair effect, as resident only slept intermittently. During the day shift, resident received pain medication with poor effect, as resident continued to be observed to have "obvious pain and discomfort" throughout the shift. Resident #002 continued to have observed pain on the evening shift, as noted in the documentation. No pain assessment was observed to have been completed.

On a specified date, resident #002 was noted to be in severe pain, and was no longer able to take any pain medication by mouth. The RN called the Physician, and left a message at a specified time, to inform of resident #002's severe pain, and inability to swallow the pain medication, therefore resident had not had any pain relief in greater than fifteen hours. There was no documentation that the Physician returned the phone call, and no new orders were received, but a pain assessment had been completed, which documented that resident's pain was described as severe, at seven out of ten. There was no further information observed within the pain assessment, related to resident #002's pain, such as location of pain, quality of pain, effect of activities of daily living on the pain, etc. During a specified shift, resident #002 sustained another fall. Resident was observed to be in pain when assessed. Documentation in the progress notes further indicated that resident #002 would be assessed by the Physician during the "next rounds", and there was no documentation to support that the Physician had been called, and no pain assessment had been completed.

On a specified date, during the night and day shifts, resident #002 was observed to be in severe pain. The Physician had been notified of resident #002's poor pain control on the day shift, and a new order was received for pain medication(s) via injection, which was first given after a specified time, on a specified date. There was no pain assessment observed to have been completed, to assess for the effectiveness of the new order. On the evening shift, resident #002 was observed to still be in pain, although it was somewhat better controlled than the day shift, due to the new pain medication order. There was no pain assessment completed which assessed the effectiveness of the new route of the pain medications.

On a specified date, resident #002 was observed to have pain prior to passing away. No pain assessments were observed to have been completed.

Inspector #672 then reviewed the internal policy entitled "Pain Management Program"; Policy number INTERD-03-10-01; approved on December 15, 2015. The policy indicated the following:

• "A screening risk assessment for pain using a clinically appropriate assessment instrument that is evidence based and specifically designed for pain assessment, is completed by registered nursing staff: within 24 hours of admission; upon any return of the resident from an absence of greater than 24 hours; quarterly according to the RAI-MDS 2.0 schedule; and when a change in health status (physical, mental, behavioural) puts a resident at increased risk for pain or pain is not relieved by initial interventions".

The policy went on to state the following:

"Homes will use a comprehensive pain assessment tool to assess pain in the cognizant and cognitively impaired resident. Assessment will include information about:
• Location of pain (includes drawing of body for visual identification of location)
• Intensity of pain (numerical indicator, facial grimace, verbal descriptor) and whether this pain is continuous, intermittent, new or old
• Quality of pain (descriptors such as aching, throbbing, shooting, stabbing, gnawing, tingling, burning)
• History of pain (diagnosis of painful disease process, accidents, other painful experiences)
• Effect on activities of daily living (e.g. appetite, sleep, rest, physical or social activities, dressing, toileting)
• Effect on behaviour (e.g. pacing, calling out, withdrawal, resistance to care, not eating or sleeping)
• Effect on quality of life (effect on happiness, contentment, fulfillment)
• Other symptoms (constipation, nausea, fatigue, depression, shortness of breath, sore mouth)
• Past pain experiences (including management methods and coping strategies used
• Resident's goal for pain management (numerical indicator and/or verbal descriptor)
• Non-pharmacological interventions tried and currently being used
• Past and current medications, including over the counter drugs and herbs (how often, how used, dosage, outcomes)
• Pain diagnosis or classification (neuropathic, nociceptive, mixed)"

During separate interviews, RN #105, RN #125, RPN #106, RPN #132 indicated that the expectation in the home was that pain assessments were to be completed upon admission to the home, quarterly, upon return from hospital, and when a resident's pain changed. This information was verified during an interview with RCC #102.

The internal policy entitled "Pain Management Program" stated the following:

"Written resident focused plans of care incorporating interventions and strategies designed to effectively manage pain including pharmacological and non-pharmacological interventions to optimize comfort and mobility will be developed within 21 days of admission. Homes will develop processes for ensuring plans of care are updated and reviewed regularly and when triggered by changes in the resident's medical condition".

Inspector #672 reviewed the current written plan of care for resident #002, and noted that there were no interventions related to the specified pain medications prescribed for resident #002 to manage the pain, and no non-pharmacological interventions to optimize comfort were observed.

The internal policy further stated:

"Homes will implement processes for immediate assessment and intervention when a resident has unmanaged pain (persistent pain at 4/10 or greater) or resident expression of pain."

Through review of resident #002's progress notes between a specified time period, the internal policy was not followed, as there were no immediate interventions observed for resident #002, when the resident's pain was not controlled over a specified period of time; or when the resident was no longer able to swallow oral medications, which lead to resident #002 not receiving any pain medication for over 39 hours, despite being observed to be in severe pain.

Therefore, the licensee failed to ensure that the internal policy entitled "Pain Management Program"; Policy number INTERD-03-10-01; approved on December 15, 2015, was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee had failed to ensure that any plan, policy, protocol, procedure,

strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

In accordance with O. Reg. 68 (2) (b) (c) the licensee shall ensure that the nutrition and hydration programs include, the identification of any risks related to nutrition care and dietary services and hydration; and the implementation of interventions to mitigate and manage those risks.

Specifically, the licensee did not comply with its policy entitled "Diet orders", FOOD-04-06-07, revised September 2014, which directed that diet orders were to be written within 24 hours of admission and as required. The Registered Dietitian was to write all diet orders on a physician's order form, which was to be implemented immediately; consent was to be obtained from the resident or SDM in order to change any diet, texture or nutritional supplement order, with the consent being documented in the electronic chart; then the nutrition care plan was to be updated.

A Critical Incident Report was submitted to the MOHLTC on a specified date, related to an incident of resident to resident physical abuse involving residents #001 and #002, resulting in an injury for resident #002.

A review of resident #002's health records showed that resident #002 returned to the home from the hospital on a specified date, with an injury. The progress notes indicated the following related to nutrition and hydration assessments:

On a specified date and time, RN #125 wrote that resident #002 returned from hospital, and ate fairly at supper. Resident's family member reported that resident had a salad in the hospital and was drinking thin fluids. RN #125 sent a referral to the Dietitian and initiated a specified diet at supper, with a specified fluid consistency, as there were no discharge papers from the hospital indicating the diet order for resident #002.

On a specified date and time, RD #135 assessed resident #002 at a meal, and recommended a specified diet, with a specified fluid consistency. RD #135 updated the dining room binder.

On a specified date and time, RD #123 re-assessed resident #002 and recommended to continue with a specified diet, and a specified fluid consistency.

Review of resident #002's Physician's orders and written plan of care was conducted by Inspector #461, which revealed that RD #135 did not write a diet order, or update the written plan of care on a specified date. On a later specified date, RD #123 updated the written plan of care, but neither RD wrote a diet order on the Physician's order form.

In an interview conducted by Inspectors #461 and #672, RD #123 reported that RD #135 assessed resident #002 on a specified date, and updated the diet on the dining room binder, but RD #135 neither wrote a diet order, nor updated the nutrition care plan. RD #135 was not available for an interview at the time of this inspection.

RD #123 further indicated that any RD in the home was expected to write all diet orders on the Physician's orders form, update the written care plan and dietary binder, and notify the staff about any changes. RD #123 confirmed that the staff were notified about the diet change, but a diet order was not written, and the written plan of care was not updated for resident #002, following the assessment completed on a specified date.

The licenses failed to ensure that the internal policy entitled "Diet orders", policy number: FOOD-04-06-07, was complied with; specifically related to the RD not writing a diet order, or updating the written plan of care for resident #002 when a diet change occurred as a result a significant change in status. [s. 8. (1) (a),s. 8. (1) (b)]

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 registered staff in the home are educated on the internal policy entitled "Pain Management Program"; Policy number INTERD-03-10-01; approved on December 15, 2015; that all registered nursing and dietary staff are educated on the internal policy entitled "Diet orders", FOOD-04-06-07, revised September 2014, and that both policies are complied with,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director on a specified date, regarding an incident of resident to resident physical abuse, which occurred on a specified date, between resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain and the resident received a diagnosis of an injury. Resident #002 returned to the home on a specified date, and passed away in the home on a later date, due to complications of the injury sustained during the altercation with resident #001.

Inspector #672 reviewed the progress notes for resident #002, for a specified period of time, until resident #002 passed away as a result of the injury sustained in the incident. Review of the progress notes indicated the following:

Resident #002 returned from hospital on the evening shift of a specified date, after being in hospital for a specified period of time. No pain assessment was observed to have been completed.

On a specified date, on all three shifts, resident #002 was noted to have symptoms of pain observed. According to the progress notes, resident #002 received a pain medication on the night shift with poor effect, and another pain medication on the day shift, with poor effect. No pain assessments were observed to have been completed.

On a specified date, during the night shift, resident #002 was noted to have non-verbal signs of pain observed. Resident #002 received pain medication, with fair effect, as resident only slept intermittently. During the day shift, resident received pain medication at the beginning of the shift, with poor effect, as resident was noted to have non-verbal signs of pain observed. No pain assessments were observed to have been completed.

On a specified date, resident #002 was observed to be in pain and received pain medication with fair effect, as the resident only slept intermittently. During the day shift, resident #002 received pain medication with poor effect, as the resident continued to be observed to have "obvious pain and discomfort". Resident #002 continued to have observed pain on the evening shift, as per documentation. No pain assessments were observed to have been completed.

On a specified date, resident #002 was noted to be in severe pain and was no longer able to take any pain medication by mouth. The RN called the Physician, and left a message at a specified time, to inform of resident #002's severe pain and inability to swallow the pain medication, which led to the resident not having any pain relief in greater than fifteen hours. There was no documentation that the Physician returned the phone call, and no new orders were received. A pain assessment had been completed, which documented that resident #002's pain was described as severe, rating at a seven out of ten. Documentation indicated that this information was passed along to the evening RN to follow up. During the evening shift, resident #002 sustained another fall, and the resident was observed to be in pain when assessed. Documentation in the progress notes further indicated that resident #002 would be assessed by the Physician during "next rounds" and there was no documentation to support that the Physician had been contacted, and no pain assessment had been completed.

On a specified date, during the night and day shifts, resident #002 was observed to be in severe pain. The Physician had been notified of the resident's poor pain control on the day shift, and a new order was received for pain medication by injection, which was first given after a specified time on a specified date. There was no pain assessment observed to have been completed, to assess for the effectiveness of the new order. On the evening shift, resident #002 was observed to still be in pain, although it was somewhat better controlled than the day shift, due to the new medication order. There was no pain assessment completed which assessed the effectiveness of the new route of the pain medications.

On a specified date, resident #002 was observed to have pain prior to passing away. No pain assessments were observed to have been completed.

During separate interviews, RN #105, RN #125, RPN #106, RPN #132 indicated that the expectation in the home was that pain assessments were to be completed upon admission to the home, quarterly, upon return from hospital, and when a resident's pain level changed. This information was verified during an interview with RCC #102.

Inspector #672 reviewed the Assessments section in the electronic documentation system, and observed that the only pain assessment completed for resident #002 appeared to have been completed on a specified date, during a specified shift, therefore the licensee failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (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 residents experiencing pain are immediately treated; when a resident's current pain treatment plan has been identified as ineffective, the physician is immediately notified; when a physician does not respond to notification in a reasonable amount of time, the registered staff move on to another physician or contact a manager for further direction,, to be implemented voluntarily.

WN #7: 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 promoted zero tolerance of abuse and neglect of residents was complied with.

Review of the licensee's "Abuse and Neglect- Prevention, Reporting and Investigation Policy", ADM-01-03-05 dated November 20, 2017, was completed and indicated:

Internal Reporting and Investigation requirements;

7. Supervisor, manager or delegate will ensure signed statements are provided by all persons involved including residents, family members, substitute decision makers, volunteers ,visitors, contractors, staff including staff against whom abuse or neglect has been alleged. All statements are required to be legible, dated and signed.

11. Supervisor, manager or delegate ensures all notifications required under the external reporting requirements has been completed and are documented in the

resident's health care record and in the investigative notes. Plan of care is to be updated if any changes to care are identified.

A Critical Incident Report was submitted to the Director on a specified date, to report a witnessed incident of resident to resident physical abuse.

During an interview with Inspectors #194 and #672, the DOC indicated that the investigation into the incident between resident #001 and resident #002 from a specified date, had been immediately initiated, with statements from RPN #106 being obtained through the progress notes in the computer.

Review of the internal investigation report provided to inspectors was completed and identified that ;

- a statement from RN #105 had been obtained with no date
- RPN #106's statement had been entered into the computer by RN #105
- PSW #113's statement was reviewed and noted to be dated 30 days after the incident
- A witness statement was not signed

A review of resident #001's plan of care did not identify changes related to responsive behaviours, regarding a specified intervention, which occurred on a specified date, and was not included in the plan of care until a later specified date. The specified intervention for resident #001 was implemented on a specified date, but was not included into the plan of care.

The licensee failed to ensure that the internal "Abuse and Neglect- Prevention, Reporting and Investigation Policy", ADM-01-03-05 dated November 20, 2017, was complied with, when statements related to an incident of resident to resident physical abuse which occurred on a specified date, were not dated and signed, and when the plan of care for resident #001 was not updated related to responsive behaviour interventions. [s. 20. (1)]

Issued on this 15th day of January, 2019 (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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by CHANTAL LAFRENIERE (194) - (A1)
Inspection No. / No de l'inspection :	2018_578672_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008844-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 15, 2019(A1)
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Terraces 600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	John Rankin

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee is ordered to:

1) Develop and implement a plan for ensuring that each resident's plan of care is reviewed and revised immediately, when the following occur:
(A) When a resident's care needs change
(B) When an intervention has been introduced to the plan of care (including the resident's response to the intervention)
(C) When an intervention is deemed to be ineffective, or no longer necessary (including why the intervention was deemed to be ineffective)
(D) When a goal is met

2) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident Report (CIR) was submitted to the Director, regarding an incident of resident to resident physical abuse, which occurred on a specified date, between

resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain, and was diagnosed with an injury. Resident #002 returned to the home on a specified date, and passed away in the home on a later specified date, due to complications of the injury sustained during the incident.

Inspector #672 reviewed the Physician's Orders and Medication Administration Record for a specified month related to resident #002, which indicated that resident had an order for a pain medication.

Inspector #672 then reviewed the progress notes for resident #002, for a specified time period, until resident #002 passed away. Review of the progress notes indicated the following:

On a specified date, on all three shifts, resident #002 was noted to have symptoms of pain observed. According to the progress notes, resident #002 received a pain medication on the night shift, with poor effect, and another pain medication on the day shift, with poor effect. There was no documentation the Physician was informed of the resident's pain control.

On a specified date, during the night shift, resident #002 was noted to have signs of pain observed. Resident #002 received a pain medication, with fair effect, as resident only slept intermittently. During the day shift, resident received a pain medication at the beginning of the shift, with poor effect, as resident was noted to have signs of pain observed. There was no documentation available from the evening shift. The documentation did not indicate that the Physician was informed of the resident's poor pain control.

On a specified date, resident was observed to be in pain, and received a pain medication with fair effect, as resident only slept intermittently. During the day shift, resident received a pain medication with poor effect, as resident continued to be observed to have "obvious pain and discomfort". Resident continued to have observed pain on the evening shift, as per documentation. There was no documentation to state the Physician was informed of the resident's poor pain control.

On a specified date, resident was noted to be in severe pain, and was no longer able

to take any pain medications by mouth. The RN called the Physician, and left a message at a specified time, to inform of resident #002's severe pain, and inability to swallow the pain medication, which had resulted in resident #002 not having any pain relief in greater than fifteen hours. There was no documentation that the Physician returned the phone call, and no new orders were received. Documentation indicated that this information was passed along to the evening RN. During the evening shift, resident #002 sustained another fall. Resident was observed to be in pain when assessed. Documentation in the progress notes further indicated that resident #002 would be assessed by the Physician during the Physician's "next rounds", and there was no documentation to support that the Physician had been contacted directly, to be informed of the fall, or resident #002's severe pain, and inability to swallow pain medications, which lead to the resident not having received any pain medication at that point in greater than 24hrs.

Inspector #672 reviewed the MAR for a specified month related to resident #002, and observed that resident #002 had not received any pain medication since a specified date and time.

During separate interviews, RN #105, RN #125, and RPN #106 indicated that they cared for resident #002 for several shifts during a specified period of time. RN #105, RPN #106, and RN #125 indicated that resident #002 appeared to be in severe pain during those shifts, but the Physician had not been notified, and resident #002's plan of care had not been reviewed and revised.

During an interview, RN #122 indicated an attempt had been made to contact the Physician on a specified date, to report that resident #002 appeared to be in severe pain, and was no longer able to take oral pain medication, but had to leave a voice message. RN #122 further indicated that another Physician had not been contacted when the primary Physician could not be reached, and had forwarded the concerns to the oncoming RN to follow up with.

During an interview, RPN #133 indicated that a specified date was the first shift working with resident #002 since the resident's return from hospital with the injury, and it had been obvious that resident #002 was in significant pain. RPN #133 contacted Physician #112, and secured an order to discontinue the oral pain medications, and initiate pain medications via injection, which was initiated in the early afternoon of a specified date.

During an interview, Physician #112 indicated staff had not brought forward concerns regarding resident #002's pain control until the morning of a specified date. Once Physician #112 became aware of resident #002's poor pain control, an order was immediately provided to discontinue the oral pain medications, and ordered pain medication via injection, which was implemented on a specified date and time.

During an interview, RCC #102 indicated that the expectation in the home was that if a resident's condition changed, and/or if the resident appeared to be in pain, or was no longer able to swallow oral medications, the registered staff should contact the Physician responsible for that resident immediately, to secure new orders. RCC #102 further indicated that if the responsible Physician could not be reached, there were multiple other Physician's employed by the home who should be contacted to secure an order for the resident.

The licensee failed to ensure that resident #002 was reassessed, and the plan of care reviewed and revised when the resident's pain was not controlled over a four day period; or when the resident was no longer able to swallow oral medications, which lead to resident #002 not receiving any pain medication for over 39 hours, despite being observed to be in severe pain. [s. 6. (10) (b)]

(672)

2. 2. The licensee has failed to ensure that the written plan of care for resident #001 was reassessed when the resident's care needs changed, and the care set out in the plan changed.

A Critical Incident Report was submitted to the Director, to report an alleged incident of resident to resident physical abuse between resident #001 and #002. The incident resulted in an injury to resident #002, which required hospitalization.

On a specified date, as a result of the resident to resident physical abuse incident, a specified intervention and assessment were implemented for resident #001.

On a specified date, a specified intervention was initiated on the night shift. On a later specified date, the same specified intervention was initiated on all three shifts. The written plan of care for resident #001 was not updated until two later dates, for the identified changes.

The specified assessment for a specified period of time identified a number of incidents where resident #001 was noted to exhibit specified responsive behaviours. The written plan of care did not identify any changes until a later date.

The licensee failed to ensure that the written plan of care for resident #001 was reassessed when the resident's care needs changed, and the care set out in the plan changed, related to specified interventions and assessments related to management of identified responsive behaviours for resident #001.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) Resident #002's plan of care specific to pain control was not reviewed and revised when their care needs changed.

2) A VPN was issued during a Resident Quality Inspection (#2015_360111_0019) on September 14, 2015, under LTCHA, 2007, s.6. A VPC was then reissued during a Complaint inspection on January 19, 2018, under LTCHA, 2007, s.6. [s. 6. (10) (b)] (672)

Nov 26, 2018

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 :

Order # / Ordre no : 002

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 is ordered to:

1) Develop and implement a communication and reporting protocol between RNs, RPNs, and PSWs, so that information regarding residents exhibiting new and/or potentially harmful responsive behaviours, experiencing poor effect with interventions currently listed within the plan of care, or a significant change in condition, is clear, accurate and acted upon immediately, including updating the written plan of care

2) Ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between residents demonstrating physically abusive responsive behaviours by implementing identified interventions.

3) Develop and implement a plan which outlines the corrective actions taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 was protected from abuse by anyone in the home.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

"emotional abuse" means, (a) 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 residents.

"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

A Critical Incident Report was submitted to the Director regarding an incident of resident to resident physical abuse, which occurred on a specified date, between resident #001 and resident #002. Resident #002 was transferred to the hospital later in the day, when the resident began to complain of pain, and the resident was diagnosed with an injury. Resident #002 returned to the home on a specified date, and the resident passed away in the home on a later specified date, due to complications related to the injury sustained during the incident with resident #001.

During a record review, resident #001's clinical health records and progress notes were reviewed during a specified time period, which revealed that resident #001 exhibited responsive behaviours, which had resulted in multiple incidents of verbal and physical behaviours directed towards staff and other residents in the home.

Resident #002's clinical health records and progress notes were reviewed during a specified time period, which revealed that resident #002 exhibited responsive behaviours.

During separate interviews, PSWs #108, #110, #111, and #113 indicated that resident #001 was known to have unpredictable responsive behaviours, which required a lot of redirection from the staff, which was not always effective. PSW #111 indicated that resident #001 and #002 had a history with each other, and that resident #002 "seemed to set off" resident #001. PSWs #108, #110, #111, and #113 further indicated that resident #001 was not receiving a specific intervention, or further interventions other than the redirection.

During an interview, RN #105 indicated that resident #001 exhibited specified responsive behaviours, and had a history of identified responsive behaviours directed towards co-residents. RN #105 further indicated that resident #002 was known to exhibit specified responsive behaviours, which could result in verbal and physical behaviours, therefore staff tried to ensure that specified interventions were implemented, which was not always effective. RN #105 indicated that at the time of

the incident between resident #001 and #002, there were several residents who resided on the home area who wandered, and staff could not supervise the residents at all times, due to being busy providing care to other residents, or being on break.

During an interview, BSO RPN #104 indicated that resident #001 had a history of exhibiting responsive behaviors. BSO RPN #104 further indicated that resident #001 had been previously discharged from the BSO program, due to a belief that the resident's behaviours had calmed down in the past two months.

Resident #001's progress notes were reviewed for a specified time period, which included documentation that between that time frame, resident #001 had been involved in five incidents of physical behaviours towards co-residents and staff, and some of the incidents had resulted in physical injuries.

During an interview, the DOC indicated being aware of resident #002 exhibiting specified responsive behaviours, and requiring specified interventions. The DOC confirmed that resident #001 was not involved in the BSO program in the home and current interventions being implemented were appropriate to manage the resident's exhibited responsive behaviours.

The licensee failed to ensure that co-residents, including resident #002 was protected from incidents of emotional and physical abuse by resident #001, pursuant to s.19 of the LTCHA. as identified by the following:

- When resident #001 was exhibiting responsive behaviours, the licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident #001's exhibited responsive behaviours. The assessments completed for resident #001 related to responsive behaviour were incomplete and not evaluated to develop and implement interventions related to responsive behaviours for resident #001, as issued under WN #7 LTCHA r. 55 (1).

- When resident #002 was exhibiting responsive behaviours, the licensee failed to identify behavioural triggers for resident #002, to reassess the interventions listed within the written plan of care, and to document the resident's responses to the interventions, as issued under WN #6, LTCHA r. 53(4)(a).

- When resident #001's care needs changed, the licensee failed to ensure that the written plan of care for resident #001 was reassessed, and the care set out in the plan changed, related to the specified interventions and assessments completed, as issued under CO #001 , LTCHA s. 6. (10)(b).

- When the incident of resident to resident physical abuse occurred between resident #001 and #002, the licensee failed to ensure that the internal "Abuse and Neglect-Prevention, Reporting and Investigation Policy", ADM-01-03-05 dated November 20, 2017, was complied with, when statements related to an incident of resident to resident physical abuse were not dated and signed, and when the plan of care for resident #001 was not updated related to responsive behaviour interventions, as issued under WN #5, LTCHA s. 20 (1).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of resident to resident abuse.

2) A WN was issued during a Resident Quality Inspection on September 14, 2015, under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 19. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2018

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee is ordered to:

(1) Review the plans of care for each resident in the home who exhibits responsive behaviours, to ensure that (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

(2) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident's responses to interventions were documented.

A Critical Incident Report was submitted to the Director, related to an incident of resident to resident physical abuse involving residents #001 and #002, which resulted in an injury to resident #002.

A review of resident #002's health records revealed that resident #002 had been exhibiting responsive behaviours prior to the incident with resident #001. A Resident's Assessment Instrument-Minimum Data Set (RAI-MDS) was completed on a specified date, with exhibited responsive behaviours noted.

A review of resident #002's progress notes for a specified period of time, related to responsive behaviours indicated:

On a specified date, RPN #106 completed a specified assessment of the resident's exhibited responsive behaviours. No update to the care plan identified.

On a specified date and time, resident #002 exhibited a responsive behaviour.

On a specified date and time, Physician #112 wrote a note regarding the resident's exhibited responsive behaviours.

On a specified date and time, RPN #106 wrote a note regarding the resident's exhibited responsive behaviours.

On a specified date and time, RPN #106 recorded an incident of exhibited responsive behaviours between resident #001 and #002.

On a specified date and time, RN #105 indicated on the falls assessment that the written plans of care for both residents related to responsive behaviours were to be reviewed. At a specified time, RN #105 wrote no goals for responsive behaviours were updated that day.

On a specified date and time, resident #002 remained in hospital with the injury sustained during the incident with resident #001.

A review of resident 002's written plan of care for responsive behaviours created on a specified date, and last revised on a specified date, identified exhibited responsive

behaviours. The were identified interventions listed. The written plan of care for resident #002 neither identified behavioral triggers nor included new interventions related to responsive behaviours.

In an interview, PSW #121 reported that resident #002 exhibited specified responsive behaviours. On a specified date, PSW #121 acknowledged that resident #002 did not require a specified intervention.

In separate interviews conducted by Inspector #461, PSW #134 and RPN #16, both indicated that resident #002 exhibited specified responsive behaviours. PSW #134 did not remember the resident having a specified intervention from the care plan implemented.

During an interview conducted by Inspectors #672 and #461, RN #125 reported that resident #002 exhibited specified responsive behaviours. RN #125 was unsure whether the resident had a specified intervention in place or not. Resident #002 had been involved with the Behavioural Support Ontario (BSO) program in the home in the past, but recently. RN #125 further reported that resident #002 had settled, hence a specified assessment or referral to the BSO program were not required.

In an interview conducted by Inspector #461, the DOC indicated being aware of resident #002 using a specified intervention, and exhibited specified responsive behaviours. The DOC confirmed that resident #002 was not involved in the BSO program in the home and current interventions being implemented were appropriate to manage the resident's exhibited responsive behaviours.

The licensee failed to identify behavioural triggers for resident #002, to reassess the interventions listed within the written plan of care, and to document the resident's responses to the interventions.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of resident to resident abuse.

2) A WN was issued during a Resident Quality Inspection on September 14, 2015,

under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 53. (4) (a)] (461)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

(A1)
The licensee is ordered to:

(1) Audit the documentation to ensure that all assessments completed have been captured within the documentation, and that a plan of care with interventions in response to the outcome of the monitoring tool have been implemented, for an eight week period.

(2) Keep a documented record of the audits conducted

(3) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

(4) Conduct periodic audits to ensure that staff are implementing the interventions as identified.

Grounds / Motifs :

1. The licensee failed to ensure that procedures and interventions were developed

and implemented to assist residents and staff who were at risk of harm, or who were harmed, as a result of a resident's behaviours; and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A Critical Incident Report was submitted to the Director to report an incident of resident to resident physical abuse, which occurred between resident #001 and #002 on a specified date and time. The altercation resulted in an injury to resident #002.

Inspector #194 reviewed the licensee's "Responsive Behaviour Prevention and Management Program"; INTERD-03-09-01; dated January 13, 2015. The 2017 Annual Program Evaluation for Responsive Behaviours was completed to verify that the Responsive Behaviour Prevention and Management Program had been reviewed, and no changes were implemented.

The Responsive Behaviour Prevention and Management Program indicated:

- An interdisciplinary screening and assessment process using the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), the (P.I.E.C.E.S.) (Physical, intellectual, Emotional, Capacities, Environment, Social) Assessment Framework, and Behavioural Supports Ontario Assessment Tool (BAT) in conjunction with additional evidence-based practice assessments as required.

- Incidents of responsive behaviours in dementia will be documented appropriately and thoroughly in the resident's chart. This documentation will assist interdisciplinary staff to understand and identify key triggers related to challenging protective behaviours and successful interventions to manage and reduce these behaviours. Documentation will reflect a focus towards providing resident focused care designed to meet the needs of residents rather than problems to be managed.

A review of resident #001's progress notes related to specified exhibited responsive behaviours during a specified period of time was completed by Inspector #194 which indicated:

Responsive behaviours towards to co-residents;

- Between a specified period of time, there were a number of incidents of resident to resident exhibited responsive behaviours, resulting in no injury.

Responsive behaviours towards staff;

A review of the clinical health record for resident #001 for a specified period of time, indicated a number of documented incidents of exhibited responsive behaviours towards staff.

Specified assessments were initiated for resident #001's responsive behaviours. During separate interviews with RCC #102 and BSO RPN #104 it was verified that PSW staff would complete the specified assessment, and report the responsive behaviours to the Registered staff on the unit. The Registered staff would then document the observed behaviours in the resident's clinical health record.

A review of the specified assessment during a specified time period, indicated no documentation recorded for nine identified shifts and four partial identified shifts. The documented behaviours on the assessment during this time period included specified exhibited responsive behaviours, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified time period, indicated no documentation recorded for four identified shifts and two partial identified shifts. The documented behaviours during this time period included specified exhibited responsive behaviours, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified period of time, indicated no documentation recorded for three identified shifts, and one partial identified shift. The documented behaviours during this time period included an exhibited responsive behaviour, with no supporting documentation in the progress notes.

A review of the specified assessment, during a specified time period indicated no documentation recorded for three identified shifts. The documented behaviours during this period included an exhibited responsive behaviour, with no supporting documentation in the progress notes.

During separate interviews conducted by Inspector #194 with DOC, RCC #102 and BSO RPN #104 there was no explanations provided related to the incomplete specified assessments or lack of documentation in the progress notes for resident

#001, related to the responsive behaviours reported by the PSW staff on the specified assessment.

Review of the BSO RPN #104's documentation in resident #001's clinical health record, during specified periods of time, indicated that resident #001 continued to exhibit specified responsive behaviours, which were often not well received by co-residents.

A review of another specified assessment for resident #001, dated a specified date, was completed. A description of the identified behaviours was provided, along with the triggers identified and current interventions being implemented.

Review of the RAI-MDS assessments for resident #001 dated a specified date, indicated multiple exhibited responsive behaviours.

Review of the RAI-MDS assessments for resident #001 dated a specified date, indicated multiple exhibited responsive behaviours.

The behavioural symptoms interventions listed within the current written plan of care indicated five interventions.

Additional interventions within a specified written plan of care indicated five interventions.

Responsive behaviour care plan intervention indicated nine interventions.

A review of the behavioural plans of care for resident #001 were completed regularly by Registered staff, with no changes identified since admission to the home, with an exception of additional interventions documented on one specified date, approximately six months later.

Medication changes noted for resident #001 during a specified period of time, related to responsive behaviours included seven medication changes/adjustments.

Interviews with PSWs # 110, 111,113, 116, 119, and 120, RN #105, RPN #106, and BSO #104 indicated that resident #001's responsive behaviour could be unpredictable at times. The interviewed staff indicated that resident #001 could

exhibit a specified responsive behaviour. Resident #001 exhibited a responsive behaviour, and redirection was utilized to manage the behaviour which was not well received by co-residents on the unit.

The licensee failed to ensure that procedures and interventions were developed and implemented related to resident #001's exhibited responsive behaviours. The assessments completed for resident #001 related to exhibited responsive behaviours were incomplete, and were not evaluated in order to develop and implement interventions related to the exhibited responsive behaviours of resident #001.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) There was an injury to resident #002, which was related to the incident of resident to resident abuse.

2) The licensee had a compliance history with non-compliance in similar areas to r.55(a), as observed with a WN being issued during a Resident Quality Inspection on September 14, 2015, under LTCHA, 2007, r. 53. A VPC was then issued during a Complaint inspection on February 24, 2016, under LTCHA, 2007, r. 53. [s. 55. (a)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 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:

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

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 15th day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CHANTAL LAFRENIERE (194) - (A1)

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

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