Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2016_414110_0008	023719-16	Resident Quality Inspection

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

DIANE BROWN (110), JANET GROUX (606), JOVAIRIA AWAN (648), KAREN MILLIGAN (650), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, 2016. September 1, 2, 2016.

During this RQI inspection the following CI (critical incidents) were inspected:
Log #017100-16, Log #019872-16, Log #014884-16, related to an allegation of staff to resident neglect.
Log #015009-15, Log #006638-16, Log #021615-15 related to an allegation of staff to

resident abuse.
Log #011289-15, Log #024632-15, Log #029252-15, Log #023355-16, Log #019468-16 Log #015317-16 Log #011730-16, Log #016477-16 and Log # 023077-16 related to an allegation of resident to resident abuse and responsive behaviours.
Log #015818-16, Log #022944-16, Log #025001-16 and Log #025277-16 related to an allegation of resident to resident abuse.
Log #007131-16 related to an allegation of improper medication administration
Log #020423-15 related to unexpected death.
Log #002502-15, Log # 021628-16 and Log #024861-16 related to a resident fall with injury.
Log #035094-15 related to a resident injury within the home.
Log #015545-16 related to an allegation of improper care related to a resident fall with injury.
The following complaints were inspected:
Log #032494-15 related to an allegation of improper medication administration.
Log #016811-16 related to an allegation of insufficient staffing and improper care of residents.
Log #005479-16 related to an allegation of resident to resident abuse.
Log #022379-16 related to an allegation of failing to protect resident right to privacy.
Log #025363-16 related to an allegation of resident to resident abuse.
The following follow-up inspection was completed:
Log #005249-16 related to previous compliance order (CO), inspection #2015_168202_0026 related to care not provided as specified in a resident's plan of care.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Director of Care (DOC), newly hired Director of Care (DOC #2), Administrator, Physiotherapist (PT), Food Service Manager, Dietary Aide, Nursing Managers (NM), Environmental Services Manager, Behaviour Care Support Worker, Manager of Clinical Information, Support Services Manager, Manager of Informatics, Residents and Families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_168202_0026	202

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of a Critical Incident (CI) report submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date revealed an allegation of resident to resident abuse.

The incident report identified that resident #074 had an identified responsive behaviour towards resident #075 while resident #075 was walking back to his/her room in a hallway without resident #075's consent.

Record review of resident #075's progress note on an identified date, revealed resident #075 reported the unwitnessed incident to his/her POA. Resident #075's POA called the home on an identified date and time and notified RPN #136 of the reported incident. The POA reported to RPN #136 that resident #074 identified responsive behaviour towards resident #075. The progress note further revealed resident #075 expressed his/her upset about the incident and was scared to go to bed.

Record review of resident #074's written care plan, identified that he/she was known to have identified responsive behaviours. Resident #074's care plan further identified the need for safety checks related to the identified responsive behaviour between resident #074 and co-residents.

Interview with resident #075 reiterated the incident as described above, identifying resident #074 with the identified responsive behaviour. Resident #075 identified the incident as abuse, and expressed that he/she had felt fear and distress due to the incident. Interview with the Administrator confirmed the incident was determined to be abuse.

The licensee failed to protect resident #075 from abuse by anyone in the home. [s. 19. (1)]

2. Review of a CI report submitted to the MOHLTC on an identified date revealed an allegation of staff to resident abuse.

Review of the CI report revealed PSW #148 inappropriately responded to resident #035's when resident reached out to the PSW. The CI further indicated that upon assessment, resident #035 sustained an injury.

Review of resident #035's progress notes revealed resident was cognitively impaired and

had identified responsive behaviours.

Review of resident #035's plan of care indicated resident had behavioural symptoms related to his/her identified medical diagnosis. The plan of care identified interventions to manage his/her behaviours.

Interview with PSW #120 revealed that he/she witnessed the incident and confirmed he/she saw PSW #148 inappropriately responded to resident #035 when resident #035 reached out to PSW #148. Interview with PSW #149 revealed he/she was nearby and heard PSW #148's inappropriate response to resident #035's responsive behaviour. They indicated this behaviour was considered unacceptable and abusive. They indicated resident #035, who was cognitively impaired, was upset about the incident.

Interview with PSW #148 revealed he/she denied that he/she abused resident #035.

Interview with the DOC revealed PSW #148's behaviour towards resident #035 was unacceptable.

The licensee failed to protect resident #035 from abuse by anyone in the home. [s. 19. (1)]

3. Review of a CI report submitted to the MOHLTC on an identified date revealed an allegation of resident to resident abuse.

The incident report identified resident #070 with responsive behaviours, as witnessed by RPN #127. The report identified the incident occurred in the common area of an identified home area on an identified date. Resident #071 was in the common area when resident #070 approached resident #071 and had an identified responsive behaviour. Resident #070 sustained an injury.

Record review of resident #071's progress notes on an identified date revealed documentation of the incident as described in the CI report. Documentation revealed that resident #071 was consoled; his/her injury addressed and monitoring was initiated.

Record review for resident #070 revealed he/she was assessed for responsive behaviours on an identified date, following the incident reported. The responsive behaviour assessment indicated an identified threat level risk and that resources in the home for behaviour management had been contacted for follow up.

Further record review of resident #070's progress notes identified he/she continued to exhibit responsive behaviours directed to staff and other residents on multiple occasions, following this reported incident.

Interview with resident # 071 reported that he/she was shaken up by the altercation with resident #070.

Interview with RPN #127 revealed he/she had responded to the altercation which was witnessed by staff and residents. RPN #127 was unable to confirm the identities of the witnessing staff and residents present at the time of the incident. Interview with RPN #127 confirmed the altercation as noted in the progress notes reviewed. RPN #127 reported routine checks were initiated for resident #070, and resident #071 was assessed for the fall.

Interview with the Administrator confirmed the home determined the incident as resident to resident abuse. The licensee failed to protect resident #071 from abuse by anyone in the home. [s. 19. (1)]

4. Review of a CI report submitted the MOHLTC on an identified date, revealed an incident of resident to resident abuse.

Review of the home's internal incident report and progress notes on an identified date indicated resident #017 approached resident #018 in a hallway and had an identified responsive behaviour towards resident #018. Resident #018 sustained an injury.

Interviews with PSW #103, RPN #104 revealed they were the staff who responded to the above incident between resident #017 and resident #018. They revealed resident #017 as having responsive behaviours and had previous incidents of an identified responsive behaviour towards another resident prior to the incident with resident #018. They stated they responded immediately to the incident and had removed resident #017 away from resident #018.

Interview with ADOC #105 confirmed resident #018 sustained an injury as a result of the incident.

The licensee failed to protect resident #018 from physical abuse by anyone in the home [s. 19. (1)]

5. Review of a CI report submitted on an identified date dated revealed an incident of resident to resident abuse.

The incident report identified that resident #024 wandered into resident #027's room and when resident #027 asked him/her to leave, resident #024 had an identified responsive behaviour towards resident #027 resulting in an injury to resident #027.

Interview with resident #027 revealed he/she remembered resident #024 entering his/her room. When interviewed by the inspector resident #027 stated that he/she felt unsafe and that different residents came into his/her room and staff will take them away. The resident reported that the staff provided support and he/she thought the police had also been contacted.

Interview with PSW #128 revealed the resident #024 was cognitively impaired and when other residents attempt to correct him/her or yell, his/her responsive behaviours escalated and it required staff to put on a smile and try to calm him/her down by being friendly to him/her.

Interview with RPN #114 revealed resident #024 had identified responsive behaviours. He/she stated staff are very aware of resident's #024 identified behaviours and are required to monitor his/her whereabouts on a frequent basis.

The licensee failed to protect resident #027 from physical abuse by anyone in the home. [s. 19. (1)]

6. Review of a CI report submitted on an identified date revealed an incident of resident to resident abuse.

Review of the CI report indicated that resident #024 had a identified responsive behaviour towards resident #020 causing resident #020 to sustain an injury.

Review of resident #024's progress notes indicated staff observed resident #020 sitting on the floor in an identified area with resident #024 standing near the door. The notes revealed resident #065 and #070 were in resident #024's personal space during the time of the incident. The staff removed resident #024 away from resident #020 and was escorted back to his/her room.

Interview with resident #024 was not completed due to his/her cognitive status.

The inspector was not able to interview residents #065 and #070 as they were not available.

Interviews with PSW #115, RPN #126 and RN #143 revealed that resident #024 had a responsive behaviour towards resident #020 causing resident #020 be sustain an injury. The above mentioned staff stated resident #024 does not like when other residents tell him/her what to do and further confirmed that resident #020 sustained identified injuries to his/her body.

The licensee failed to protect resident #020 from physical abuse by anyone in the home. [s. 19. (1)]

7. Review of a CI report submitted on an identified date, revealed an incident of resident to resident abuse.

Review of the CI report identified that resident #024 had a responsive behaviour towards resident #026 causing injury to resident #026 when resident #026 told him/her not to touch his/her belongings.

Review of resident #026's progress notes indicated he/she was sitting in a lounge in the home when resident #024 took an item from resident #026. An altercation ensued resulting in identified injuries to resident #026.

Review of resident #024's progress notes indicated the resident had exhibited identified responsive behaviours toward resident #026 when resident resident #026 attempted to take his/her item.

Interviews with RPNs #126 and #127 revealed resident #024 had a responsive behaviour when resident #026 told him/her not to touch his/her item resulting in an altercation and injury to resident #026.

The licensee failed to protect resident #026 from abuse by anyone in the home. [s. 19. (1)]

8. Review of a CI reported submitted on an identified date, revealed a incident of resident to resident abuse.

Review of resident #024 and #025's progress notes identified that a staff member observed resident #024 in resident #025's room with an identified responsive behaviour towards resident #025.

Review of resident #025's progress notes indicated PSW #130 witnessed resident #024 in resident #025's room and reported that resident #024 had an identified responsive behaviour towards resident #025.

Interview with PSW #130 revealed he/she witnessed the incident as mentioned above and removed resident #024 away from resident #025. He/she indicated resident #025 was observed to be visibly upset at what had happened and he/she calmed and reassured the resident.

Interviews with NM #143 revealed resident #024 had a history of identified responsive behaviours towards other residents and confirmed this was the first incident that resident #024 had a responsive behaviour of this type towards another resident. [s. 19. (1)]

9. Review of a CI submitted on an identified date revealed an incident of resident to resident abuse.

Review of resident #021's progress notes revealed the resident was identified with identified responsive behaviour towards staff and other residents.
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Interviews with PSW #112 and RPN #118 revealed resident #021 was identified with responsive behaviours and confirmed that resident #021 was observed with these behaviours towards resident #022 on the identified date and that staff were not able to intervene until after the incident occurred.

The licensee has failed to ensure resident #022 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The home submitted a CI report on an identified date related to resident #047's unexpected death. The physician, resident and substitute decision maker (SDM) discussed a change and deterioration in resident #047's condition. The change in resident #047's condition involved symptoms related to the deterioration in health. Following the discussion with the SDM, it was decided that resident #047's care consisted of comfort measures only. This occurred shortly prior to the death of resident #047.

Record review revealed the following:
- Resident #047 was admitted on an identified date
- The initial written plan of care was developed over a one week period following admission.
- The written plan of care was reviewed or revised on identified dates in the following month.
- On a later identified date, resident #047 was placed on comfort measures only and the plan of care, including the written care plan and kardex were not reviewed or revised to reflect his/her current needs or change in medical condition.

An interview with the DOC confirmed resident #047's written plan of care failed to identify the change in his/her condition identified as comfort measures only as set out in the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The home submitted a CI report on an identified date. The report indicated that resident #080 had been taken to hospital following an unwitnessed fall. Resident #080 was admitted to hospital for treatment to a sustained injury and returned back to home on an identified date and passed after an identified time period of returning to the home.

A review of resident #080's clinical records indicated that resident #080 had been at moderate risk for falls. Fall prevention strategies were recorded on resident #080's written plan of care

Interview with NM #143 revealed that resident #080 brought a fall prevention device in from home and used them as a strategy to manage residents risk of falls but this strategy was not documented on the written plan of care as a fall prevention strategy.

Interviews with PSWs #108, #141, #140, #159 and RN #142 revealed that resident #080 used the fall prevention device.

An interview with RN #142 further revealed that on July 13, 2016, resident #080 was found sitting on the floor and told RN #142 that he/she was glad that he/she had used his/her fall prevention device.

Interviews with NM #143 and RN #117 confirmed that resident #080's written plan of care did not identify that he/she used the fall prevention device.

Interviews with NM #111 and DON #124 confirmed that the home failed to ensure that the written plan of care for resident #080 set out any direction to staff and others who provide direct care to the resident with respect to the use of the resident's device [s. 6. (1) (c)]

3. The home submitted a CI report on an identified date reporting an allegation of resident to resident abuse. The incident witnessed by staff, identified resident #021 have an identified responsive behaviour towards resident #022's on an identified date and time.

Review of resident #021's progress notes revealed ongoing incidents of identified responsive behaviours towards staff and identified co-residents. There were an identified number of documented incidents over a three month identified period of time, whereby resident #021 had identified responsive behaviours towards identified identified residents.

Review of resident #021's written plan of care identified that resident #021 exhibits identified responsive behaviour towards staff. The plan of care did not identify that resident exhibits the identified responsive behaviour towards other residents.

Interviews with PSW #146 and RPN #118 revealed resident #021 was identified on admission as having responsive behaviours and could be inappropriate towards staff. Staff revealed they were unaware of previous incidents of identified responsive behaviour towards other female residents prior to the incident identified on the CI report submitted to the MOHLTC.

Interviews with the ADOC and DOC revealed it was the home's practice to assess the

resident when there is a change in their needs and update the plan of care. However, in this situation this has not occurred.

The licensee failed to ensure that there was a written plan of care for resident #021 that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted a CI report on an identified date reporting resident #029 was sent to hospital for investigation following complaints of pain and issues related to mobility and weight bearing status. Resident was subsequently admitted to the hospital due to an identified diagnosis and returned back to home, diagnosed with an identified injury.

Review of resident #029's clinical records revealed he/she had a history of an identified condition and was receiving a supplement as treatment.

A review of resident #029's clinical records over a period of eight months in 2016, identified that the resident was at moderate/high for falls and had fallen on an identified number of occasions.

A review of resident #029's written plan of care identified interventions for identified interventions for falls prevention and management.

On three identified dates, during the RQI inspector #650 observed resident #029 and without the identified interventions for falls prevention and management in place.

The above mentioned observations were confirmed by PSW #100, RN #127 and PSW #138 respectively.

Interviews with Nurse Manager #155, PSW #100, PSW #145 and PSW #138 confirmed that resident #029 was at moderate/high risk for falls and that fall prevention strategies identified in resident #029's plan of care had not been provided to the resident as specified on the identified dates. [s. 6. (7)]

5. The home submitted a CI report on an identified date, reporting an allegation of staff to resident abuse. The report indicated PSW #116 and #145 reported PSW # 158 was

abusive towards resident #037 on two occasions.

Review of resident #037's written plan of care revealed resident had a diagnosis that resulted in his/her having difficulty clearly communicating. Further review of the plan of care directed staff to use alternative strategies to support communication with the resident.

The inspector attempted to contact PSW #116 and #145, leaving voice messages but was unable to reach them.

The inspector attempted to contact PSW #158 for an interview but was unable to reach him/her at the telephone number provided as he/she no longer resided at the number.

Interviews with the NM and DOC indicated staff communicated with resident #037 through identified strategies to facilitate communication with the resident.

The DOC revealed the home's investigation concluded PSW #058 had attempted to communicate with resident #037 but did not follow the interventions as specified in the plan of care. [s. 6. (7)]

6. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

Resident #003 was identified during a staff interview and chart review to have a specified area of impaired skin integrity.

During a record review of resident #003's treatment for the area of impaired skin integrity in the electronic treatment administration records (eTAR) the following prescribed treatment interventions were not signed as complete and not documented as providing the prescribed treatment interventions.

On an identified date the prescribed treatment interventions identified a specific regiment to be applied to the resident. The treatment interventions were not documented as completed on the eTAR on seven identified incidences over a two month period in 2016.

Resident #003 was also identified with an another area of impaired skin integrity.The resident's plan of care identified a specific regiment to be applied based on the determined schedule. The treatment interventions were not documented as completed

on the eTAR on two scheduled instances within one month in 2016.

On an identified date, the prescribed treatment interventions to one of resident #003's areas of impaired skin integrity identified the treatment was to be applied on a specified schedule. The treatment interventions were not documented as completed on the eTAR on two scheduled instances within one month in 2016.

On an identified date, the prescribed treatment interventions to resident #003's area of impaired skin integrity noted above were changed, and required to be applied on a more frequent basis.

The treatment interventions were not documented as completed on the eTAR in nine identified instances over a period of two months in 2016

An interview with RPN #104 and NM #105 confirmed the registered staff who performed the treatment changes did not document in the eTARs to indicate the treatment interventions had been completed as directed in the plan of care. [s. 6. (9) 1.]

7. The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary.

The home submitted a CI report to the MOHLTC on an identified date reporting that resident #035 received another resident's medication related to RPN #179 misidentifying the two residents. Resident #035 was sent to the hospital emergency department for assessment.

Record review of resident #035's plan of care included a section created on an identified date indicating the resident preference to wear his/her identification bracelet.
- Written care plan identified resident #035 preference not to wear his/her identification bracelet. This section on the plan of care was created on an identified date. The goal remained the same for resident #035 to be safely identified and the risks and outcomes of not wearing an identification bracelet were to be reviewed at a later identified date. The interventions were revised after the incident in 2016, and identified as follows: document in progress notes refusal actions taken by the RN/RPN; to ensure the unit supervisor is aware of preference around not wearing of bracelet; staff to ask the resident their full name and staff will identify resident using current photo on eMAR.
- Tasks identified for the PSWs included to document if resident is wearing an

identification armband. The task record was reviewed for the time period prior to and after the incident between a period of four months in 2016. There was no identification documentation completed by the PSWs related to whether the identification bracelet was worn by resident #035 or not. The eMAR had no alerts identified to indicate a high alert for same names.

An interview with RPN #179 confirmed he/she did administer the wrong medication to resident #035. When asked how this happened the RPN stated that it was his/her first or second shift working by him/herself as he/she was new to the home. The RPN indicated that he/she had checked the resident but the resident could not confirm his/her name and the RPN looked at the eMAR photo, both resident #035 and #048 looked similar. The RPN then asked a PSW the name of the identified resident whom he/she thought was resident #035. The PSW told him/her it was the resident he/she wanted. The RPN said he/she asked the PSW three times and that the PSW confirmed the resident's name. Later in the shift the RPN found out that the PSW was also new and confirmed that resident #035 had the same first name as another resident. He/she confirmed the resident did not have an identification band on for him/her to confirm resident #035's identity.

An interview with RN #142 and RPN #179 both confirmed resident #035 does not wear an identification band and that the PSWs did not document as having checked for an identification band for a period of four months even though they were directed to through the task documentation. When RPN #153 and #179 were asked if the plan of care reflected the current needs of the resident their response was no. Both RPNs agreed the plan of care required revision and review as it did not reflect resident #035's current needs.

An interview with the DOC confirmed resident #035's plan of care required to be reviewed and revised when the resident's care needs changed related to the refusal to wear an identification bracelet. [s. 6. (10) (b)]

8. Review of a CI report submitted on an identified date, revealed an incident of resident to resident abuse. The report indicated resident #017 approached resident #018 in a hallway and had an identified responsive behaviour towards resident #018 causing #018 to sustain an injury.

Review of resident #017's progress notes and incident reports revealed the resident had three reported incidents of identified responsive behaviours prior to the reported incident

with resident #018.

Review of resident #017's plan of care initiated on an identified date, identified resident #017 to be high risk for identified responsive behaviours . The plan of care directed staff on strategies to manage residents identified responsive behaviours.

Resident's responsive behaviours were not identified in his/her written plan of care until after the incident with resident #018.

Interview with resident #018 was not completed due to his/her cognitive status.

Interview with resident #017 was not completed as he/she is no longer in the home.

Interviews with PSW #103, RPN #104, and ADOC #105 revealed resident #017 had been identified as having responsive behaviours and had previous incidents an identified responsive behaviour towards another resident prior to this incident with resident #018.

The home failed to failed to ensure the resident was assessed and the plan of care when resident #017 had a change in his/her condition. [s. 6. (10) (b)]

9. Review of a CI report submitted on an identified date revealed an incident of resident to resident abuse.

The report indicated resident #017 approached resident #018 in the hallway, had a identified responsive behaviour resulting in an injury to resident #018.

Review of resident #017's progress notes and incident reports revealed resident had three incidents of an identified responsive behaviour prior to the incident with resident #018

Review of resident #017's plan of care, identified resident #017 to be high risk for identified responsive behaviours. The plan of care directed staff on strategies to manage residents identified responsive behaviours.

Resident's responsive behaviours were not identified in his/her written plan of care until after the incident with resident #018.

Interview with resident #018 was not completed due to his/her cognitive status.

Interview with resident #017 was not completed as he/she is no longer in the home.

Interviews with PSW #103, RPN #104, and ADOC #105 revealed resident #017 as having responsive behaviours and had previous incidents whereby the resident exhibited identified responsive behaviours towards another resident prior to this incident with resident #018. [s. 6. (10) (b)]

10. The licensee has failed to 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, (c) care set out in the plan has not been effective.

Review of a complaint submitted to the MOHLTC on an identified date revealed resident #028 had concerns with other residents entering his/her room, taking his/her personal belongings, and threatening resident.

Review of CI report on an identified date reported resident #029 entered resident #028's room and had an identified responsive behaviours towards resident #028.

Review of resident #028's progress notes revealed on the identified date resident #029 entered resident #028's room and had an identified responsive behaviours towards a visitor and resident #028. It was documented that staff were informed via call bell and no further follow up was done regarding this incident.

Review of resident #028's written plan of care dated revealed co-residents will be deterred from entering resident's room through the use of specified measures.

Interview with resident #028 and his/her SDM revealed they had expressed concerns on two identified dates and within one month, to the home regarding residents wandering into resident #028's room, taking his/her belongings along with concerns for his/her safety.

Interview with PSW #116 and RPN #110 revealed resident #028's had an intervention in place to deter other residents from entering the room and an additional intervention to alert staff when a resident attempted to enter resident #028's room. The staff monitor residents who have been identified to wander into other residents' rooms on an ongoing basis. Staff confirmed the plan of care was not always effective and no other approaches have been tried. [s. 6. (10) (c)]

11. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Review of a CI report submitted on an identified date reported resident to resident abuse between resident #035 and #036.The report indicated resident #035 entered resident #036's room and exhibited an identified responsive behaviour toward resident #036.

Review of resident #035's written plan of care identified resident with responsive behaviour, Level Red Behaviour symptoms related to a diagnosis and indicated the resident's written plan of care was not revised and updated. The plan of care included interventions to prevent and manage resident #035's responsive behaviours.

Interview with RPN #102 revealed resident #035 had been identified to have responsive behaviours and has had several incidents involving other residents prior to this incident. He/she further revealed the plan of care directs staff to monitor resident and prevent altercations with other residents, and that there had been no changes in the interventions.

Interview with NM #105 revealed that resident was identified prior to the incident as having identified responsive behaviours towards others and the home managed it by continuing to monitor resident as before. He/she indicated that the incident between resident #035 and #036 resulted in resident #036 sustaining identified injury. [s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident; the plan of care set out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 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 is complied with.

The home's "Personal Hygiene and Grooming", "Cleaning of Medical/Personal Care Equipment and Contact Surfaces" and "Isolation" policies identified the following related to labeling of personal care items.

Resident Care and Service Manual, section "Activities of Daily Living", index ID "D-05", subject "Personal Hygiene and Grooming", revised date March 10, 2016, identified that residents with grooming aids such as hair brushes and tooth paste and personal items

will be labeled.

Resident Care and Service Manual, section "Resident Safety", index ID "E-80", subject "Cleaning of Medical/Personal Care Equipment and Contact Surfaces", revised date March 10, 2016, identified that all personal care items are to be labeled and are not to be used for other residents.

Infection Prevention and Control Manual, section "Isolation", index ID "IFC-F-05", subject "Additional Precautions", revised date May 25, 2016, identified under the Personal Effects section that all personal items such as lotions, creams and razors should not be shared with other residents and under Personal Care Supplies the following items should not be shared with other residents lotions, creams, soaps, razors, combs, brushes, etcetera.

On August 15, 2016, day one of the Resident Quality Inspection (RQI) the inspector observed the following unlabeled personal care items:
Home area 2 East, spa room – used nail clippers,
Home area 2 West, spa room – disposable razor, four used nail clippers, deodorant, used hair brush with strands of hair and a used bar soap,
Home area 3 East, spa room - body butter which had been used,
Home area 3 West, washroom at entrance to unit – used hair brush with strands of hair.

On August 16, 2016, day two of the inspection, RPN's #122, #125, #126 and #127 confirmed the above identified unlabeled items in the identified home areas. The registered staff could not identify if the items belonged to any resident as they were not labeled. The registered staff removed and discarded the items.

The DOC confirmed the home did not follow their policy in regards to ensuring all items are labeled and it is expected that resident's personal items are labelled. [s. 8. (1)] (557)

2. The home's policy in the Resident Care and Service Manual, section "Medication Administration", index ID "F-05", subject "General Policy", revised date March 10, 2016, identified all medications administered must be signed off electronically as given by the registered staff as soon as the medication is administered.

The physician prescribed treatment protocols for resident #003, as follows:
- Resident #003 had an identified area of impaired skin integrity.
- On a specified date, staff to provide interventions as outlined in the plan of care. This

was not documented on the electronic medication administration records (eMAR) as completing the treatment of seven identified dates between a period of two months in 2016.
- Resident #003 had an area of impaired skin integrity. The treatment protocol identified the interventions that were to be applied based on a specified schedule. This was not documented on the eMAR as completing the treatment on two identified dates in one month in 2016.
- On an identified date, the treatment protocol to resident #003's area of impaired skin integrity was changed and was to be applied based on a specified schedule. This was not documented on the eMAR as completing the treatment on two identified dates in one month in 2016.
- On identified date, the treatment protocol to resident #003's area of impaired skin integrity was changed and was to be applied based on a specified schedule. This was not documented on the eMAR as completing the treatment on eight identified dates over a period of two months in 2016,

An interview with RPN #104 upon review of the eMAR's confirmed the eMAR's were not documented on the above noted dates and could not confirm if the treatment to resident #003 had occurred.

An interview with the DOC confirmed treatment protocols are part of medication administration. He/she further stated if the treatment was not given then the registered staff would identify this on the eMAR. He/she confirmed that registered staff did not follow the home's policy and procedures and it was an expectation that the registered staff document in the eMAR's after the completion of the treatment protocols. [s. 8. (1) (b)] (557)

3. The home's policy in the Resident Care and Service Manual, section "Admissions, Transfers and Discharges", index ID "B-25", subject "Discharge of a Resident", revised date March 10, 2016, directed registered staff to obtain a physician's order for discharge and to destroy or send the medications with the resident and to document in the progress notes the discharge. The DOC confirmed the same practices for discharge apply to short stay residents.

The home's policy in the Resident Care and Service Manual, section "Clinical Records", index ID "H-40", subject "Discharged/deceased Resident Clinical Records", revised date March 10, 2016, identified that the physician or registered nurse extended class was to write an order for discharge and an order to destroy the drugs and to complete a

discharge summary.

During the RQI, a complaint submitted to the MOHLTC was inspected with respect to resident #046. The complainant indicated he/she had admitted resident #046 to the home for a short stay program. The substitute decision maker (SDM) complained that he/she had to pay for a medical intervention required by the resident which the home destroyed rather than sending it home with the resident upon discharge.

Record review of the plan of care for resident #046 revealed the following:
- New admission order form which confirmed identified medications including dosage, frequency, and time of administration for the resident.
- MediSystem packing slip on an identified date, confirmed MediSystem sent a specified amount for each of the medications noted.
- eMAR's confirmed the resident was administered a specified amount or quantity of identified medications for the duration of his/her stay in the home.
- for each identified medication, a specified amount of remaining dosages was determined.
- Physician Order's sheet no discharge order observed to destroy medications.
- Progress notes no discharge summary entered.

Staff interviews with RPN #157 and #158 confirmed they destroy the medications in general when a resident is deceased or discharged, unless they have brought their own personal medication into the home. RPN #158 confirmed that he/she did not send the remaining medication home with resident #046 after discharge, nor did he/she obtain a physician order to destroy the medication.

An interview with the DOC confirmed the registered staff did not follow the home's policies to obtain a physician's order to destroy or send the medication home with resident #046 and that the nurse did not document a discharge summary in the progress notes. The DOC confirmed it is the expectation that the registered staff follow the home's policy and procedures.

The home's policy in the Resident Care and Service Manual, section "Medication Administration", index ID "F-35", subject "Drug Destruction and Disposal", revised date March 10, 2016, identified that when destroying narcotics or controlled substances the following must be recorded - quantity.

The inspector observed through a record review of resident #046's plan of care the following documents:
- On an identified date, the pharmacy supplied a specific amount of a medication.
- eMAR indicated that a specified amount of the medication was administered to resident #046 during the identified time period..
- The Narcotic Surplus Drug record indicated the quantity destroyed was a specified number of tablets.
- The Narcotic and Controlled Substance Administration Record identified a count of differing number of tablets remained on the blister pack.

An interview with the DOC confirmed there an identified amount of the medication was destroyed and that the pharmacist and the DOC designate documented the wrong quantity of tablets on an identified date The DOC confirmed it was documented as per policy but incorrectly.

The home's policy in the Resident Care and Service Manual, section "Medication Administration", index ID "F-15", subject "Receiving Medications", revised date March 10, 2016, identified that all medications received are signed for by a registered staff member, the receiving nurse for the medication delivery will sign for the medication verifying that it was received. The policy further stated it was to be current, accurate and complete.

Interviews with RPN #157 and #158 confirmed they do not sign the shipping receipt as they do not have time when they receive the weekly batch of medications as there are too many drugs and residents to verify.

An interview with the DOC confirmed the registered nursing staff are to follow the home's policy and procedures to ensure accurate delivery of medication to all residents.

The Pharmacy's policy in the Pharmacy Manual, section "Medication Pass", Index Number "04-02-
20", subject "Medication Pass - Procedure", last reviewed date June 23, 2014, identified the Eight Rights of Medication Administration, to ensure the right resident and to verify the resident's identity using two identifiers.

During the RQI, a CI report made to the MOHLTC was inspected with respect to resident #035.The CI indicated resident #035 received resident #048's medication.

An interview with RPN # 159 confirmed he/she administered the wrong medication to resident #035. He/she confirmed that he/she did not have the right resident identified nor did he/she use proper identifiers. The RPN further stated the identifiers he/she used were not appropriate for a new staff member, as the photo identification on the eMAR was old and the PSW he/she asked to verify the resident was also new, the PSW had the right first name but the surname was incorrect.

The DOC confirmed that the RPN did not identify resident #035 correctly and if he/she had the resident would not have received the wrong medication. The DOC confirmed it was the expectation of the home that all registered staff follow the home's policies when administering medication to residents. [s. 8. (1) (b)] (557) [s. 8. (1) (b)] (557)

4. The home's Quality Improvement Program Manual, section III "Risk and Quality Indicators and Tools", Index Number "Social Services", subject "Client Service Response Form", last reviewed date May 30, 2016, identified that a Client Service Response Form was to be completed by any person receiving a complaint or concern; that he/she was to document the complaint or concern onto the form and was to distribute the form to the relevant department and copy the social worker or social service worker and the administrator.

During the RQI, a complaint made to the MOHTLC was inspected with respect to resident #046. The complainant indicated he/she had admitted resident #046 for a short stay program. The substitute decision maker (SDM) complained that the resident did not receive his/her prescribed medications during the duration of his/her stay.

An interview with the SDM in regards to the complaint revealed the SDM had called the home and spoke with RPN #158, either the same evening of discharge or the following morning to follow up on why resident #046 did not receive his/her prescribed medication during the resident's stay at the home. The complainant further indicated an estimated number of dosages for a different prescribed medication was not used but paid for by the family and queried as to where they were.

An interview with RPN #158 confirmed he/she remembered talking to the SDM about one of resident #046's prescribed medications, however, does not recall a conversation about the other which the SDM reported had not been administered. RPN #158 did not complete a complaint form.

An interview with the DOC revealed he/she had not been informed nor had he/she received a Client Service Response Form. The DOC looked in the home's complaint or concern binder and no document was found. He/she further stated if he/she had known about the concern about the medication the home would have reimbursed the family. The DOC confirmed that RPN #158 did not comply with the home's procedure to complete the Client Service Response Form and it is an expectation that the form's are completed if anyone brings forward a complaint or concern. [s. 8. (1) (b)] (557)

5. Review of the home's policy entitled, "Responsive Behaviour Philosophy" reviewed April 12, 2016, indicated:
-within 24 hours after admission of a resident, the Responsive Behaviour Risk Screening tool in the electronic documentation system will be used to identify different risk levels of behaviours, triggers and interventions.
-this information will be found in the CCAC documentation, information from family member and staff observation to complete the Responsive Behaviour Risk Screening tool.
-this information will be used until the first admission RAI-MDS Assessment has been completed and;
-the identified responsive behaviours and the possible triggers are communicated to all staff and heightened monitoring will occur which will include daily charting in the progress notes in the electronic documentation system until the behaviour is controlled.

Review of resident #021's PCC admission assessments revealed no indication the resident had a Responsive Behaviour Risk Screening assessment completed.

Review of CI report made to the MOHLTC on an identified date, reported resident to resident abuse. The incident report identified staff witnessing resident #021 exhibiting and identified responsive behaviour toward resident #022 in the an identified area, on an identified date.

Review of another CI report made to the MOHLTC on an identified date, reported resident to resident abuse.

Interviews with RN #111 and the DOC revealed all residents who are admitted to the home are assessed for responsive behaviours using Responsive Behaviour Risk Screening Tool and this did not occur for resident #021. [s. 8. (1) (b)] (606)

6. Review of the home's policy entitled, "Responsive Behaviour Philosophy" reviewed April 12, 2016, indicated:
-within 24 hours after admission of a resident, the Responsive Behaviour Risk Screening tool in the electronic documentation system will be used to identify different risk levels of behaviours, triggers and interventions.
-this information will be found in the CCAC documentation, information from family member and staff observation to complete the Responsive Behaviour Risk Screening tool.
-this information will be used until the first admission RAI-MDS Assessment has been completed and;
-the identified responsive behaviours and the possible triggers are communicated to all staff and heightened monitoring will occur which will include daily charting in the progress notes in the electronic documentation system until the behaviour is controlled.

Review of resident #021's PCC admission assessments revealed no indication the resident had a Responsive Behaviour Risk Screening assessment completed.

Review of CI report made to the MOHLTC on an identified date, reported resident to resident abuse. The incident report identified staff witnessing resident #021 exhibiting and identified responsive behaviour toward resident #022 in an identified area on an identified date. Review of another CI report made to the MOHLTC on an identified date, reported resident to resident abuse.

Interviews with RN #111 and the DOC revealed all residents who are admitted to the home are assessed for responsive behaviours using Responsive Behaviour Risk Screening Tool and this did not occur for resident #021. [s. 8. (1) (b)] (606)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home policies related to "Resident Special Needs", subject "End of Life Care Checklist"; "Personal Hygiene and Grooming"; "Cleaning of Medical/Personal Care Equipment and Contact Surfaces" and "Isolation"; "Personal Hygiene and Grooming"; "Medication Administration"; "Admissions, Transfers and Discharges"; "Client Service Response Form"; "Responsive Behaviour Philosophy"; "Abuse and Neglect" ; put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment that includes the resident's health conditions including allergies, pain, risk of falls and other special needs.

The home submitted a CI report made to the MOHLTC on an identified date, indicating that resident #080 had been taken to hospital following an unwitnessed fall on an identified date. Resident #080 was admitted to hospital for treatment and returned back to the home on a later identified date. The resident died on an identified date following his/her return to the home.

A review of the plan of care for resident #080 revealed that he/she had been at moderate risk for falls related to identified contributing factors.

Fall prevention strategies were recorded on resident #080's written plan of care to manage falls risk.

Interviews with PSWs #108, #141, #140 and RN #143 indicated that resident #080 had a fall prevention aide and had brought it in on admission. RN #143 further indicated that resident #080 had not been assessed for use of the aide as a fall prevention strategy.

At the time of the identified fall, RN #142 indicated in an interview that resident #080 was found with the fall prevention aide in place.

A further review of resident #080's written plan of care revealed that the use of the fall prevention aide had not been documented as a fall prevention strategy and confirmed by the DON in an interview. [s. 26. (3) 10.] (650

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment that includes the resident's health conditions including risk of falls and other special needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Review of CI report made to the MOHLTC on an identified date, reported that resident #035 received another residents medication.

Record review of residents #035 plan of care revealed the following:
- eMAR confirmed resident #035's medications were held at a specified time.
- Progress notes confirmed resident #035 received identified medications that belonged to another resident.
- Progress notes confirmed contacting the physician and following the physician orders as identified to call poison control, monitor resident and take vital signs hourly.
- Poison control advised to send resident to hospital for close monitoring as resident had received more than a specified amount for an identified medication.

A staff interview with RPN #159 confirmed he/she did administer the wrong medication to resident #035. When asked how this happened the RPN said that it was his/her first shift working by him/herself as he/she was new to the home. The RPN indicated that the resident did not confirm his/her name and the resident looked similar to another resident whom he/she thought was resident #035. The PSW told him/her it was the resident he/she requested. The RPN said they asked three times and that the PSW confirmed the resident's name. Later the RPN found out that the PSW was also new and confirmed that resident #035 had the same first name as another resident. RPN #159 said the photo identification had now been updated and there were name alerts on the medication bin put into practice.

An interview with the DOC confirmed there were two residents with the same first name and the RPN should have used photo identification to identify the residents from the eMAR. The DOC also confirmed that resident #035 received medication that was not prescribed for him/her. [s. 131. (1)] (557)

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During the building tour, August 15, 2016, day one of the unannounced RQI, the inspector of the RQI observed the following unlabeled personal care items; Home area 2 East, spa room – used nail clippers,
Home area 2 West, spa room – disposable razor, four used nail clippers, deodorant, used hair brush with strands of hair and a used bar soap,
Home area 3 East, spa room - body butter which had been used,
Home area 3 West, washroom at entrance to unit – used hair brush with strands of hair.

On day two, August 16, 2016, the above items still remained within the identified home area spa rooms. The inspector and the RPNs within the specific home areas confirmed the unlabeled items as follows;
RPN #127 confirmed home area 2 East, spa room - used nail clippers,
RPN #122 confirmed home area 2 West, spa room - disposable razor, four used nail clippers, deodorant, used hair brush with strands of hair and a used bar soap,
RPN #126 confirmed home area 3 East, spa room - body butter which had been used and RPN #125 confirmed home area 3 West, washroom at entrance to unit unlabeled hair brush with strands of hair.

Interviews with the identified RPNs confirmed this was not the home's practice to leave unlabeled care items as identified in common shared home areas. The RPNs removed and discarded the unlabeled items that were identified.

The home's Infection Prevention and Control Manual, section "Isolation", index ID "IFC-F-05", subject "Additional Precautions", revised date May 25, 2016, identifies under the Personal Effects section identifies that all personal items such as lotions, creams and razors should not be shared with other residents and under Personal Care Supplies the following items should not be shared with other residents lotions, creams, soaps, razors, combs, brushes, etcetera.

An interview with the DOC confirmed that staff did not follow the home's infection prevention program by leaving unlabeled personal items in the common area of the spa room. He/she further stated that it is the expectation that all staff participate in the infection control program. [s. 229. (4)] (557)

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 staff participate in the implementation of the infection prevention and control program by way of labeling residents' personal care items, 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 promotes zero tolerance of abuse and neglect of residents was complied with.

Record review of the home's Abuse and Neglect Policy - Revised March 10, 2016, identified in section 26, on page 10, that residents who have or may have been subject to abuse or neglect would be assisted by the home through counseling services as coordinated by the social services coordinator.

Record review of resident #071's progress notes did not include documentation to demonstrate counseling was offered to resident #071 by the social service coordinator.

Interview with the Administrator confirmed that resident #071 was not provided assistance as outlined in the home's Abuse and Neglect Policy.

The licensee failed to ensure that the home provided assistance to resident #071 after being subjected to abuse by a co-resident, in keeping with their policy. [s. 20. (1)] (648)

2. Review of a CI report made to the MOHLTC on an identified date, reported an allegation of resident to resident abuse.

The incident report identified that staff witnessed resident #021 have an identified responsive behaviour towards resident #022 in an identified area on an identified date.

Review of resident #022's progress notes revealed resident was upset by the incident.

Interviews with the SDM revealed that the incident was upsetting to resident #022 and the resident had verbalized to him/her being afraid of another incident happening.

Interview with the manager of informatics #117, the DOC, and the administrator revealed residents who are involved in incidents of abuse are referred to a social worker and offered counseling. Interviews confirmed that resident #022 was not referred and did not receive counseling. [s. 20. (1)] (606)

3. Review of a CI report made to the MOHLTC on an identified date, reported resident to resident abuse. The incident report identified that resident #021 had wandered into resident #023's room and was witnessed by a staff member resident #021 had an identified responsive behaviour towards resident #023.

Review of resident #023's progress notes and interview with PSW #146 revealed resident was upset by the incident.

Interviews with the manager of informatics #117, the DOC, and the administrator revealed residents who are involved in incidents of the above nature are referred to a social worker and offered counseling. They confirmed that resident #23 was not referred and did not receive counseling. [s. 20. (1)] (606)

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse and neglect of residents that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Review of CI report submitted to the MOHLTC on an identified date, reported resident to resident abuse. The incident report identified a staff witnessing resident #021 having identified responsive behaviours towards resident #022 in an identified area on an identified date.

Review of the resident #022's progress notes and the home's investigation records revealed an investigation was not initiated until the day after the incident.

Interview with PSW #112 revealed he/she reported the incident immediately to the charge nurse after it happened.

Interview with RPN #118 revealed the incident occurred at an identified time and confirmed that he/she should have reported it to the ADOC immediately but did not until later that afternoon.

Interview with the DOC confirmed the incident occurred on the identified date, but the home did not initiate an investigation until the next day. [s. 23. (1) (a)] (606)

2. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Record review of CI report made to the MOHLTC on an identified date, directed the home to amend and resubmit the CI to include the following: a history of an identified residents behaviours towards other residents; resident's level of cognition; any POA/family voiced concerns and strategies and/or interventions planned to prevent recurrence. Review of the CI did not include amended notes for the CI inspected. Review of the CI system on the long term care homes portal failed to identify an amended CI submitted with the information requested.

Interview with Administrator confirmed an amended CI was not submitted to the Director, as requested by way of a note, in the general comments section of the initial CI.

The licensee failed to submit an amended CI reporting the results of the investigation as requested by the Director. [s. 23. (2)] (648)

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director:

Review of report made to the MOHLTC on an identified date, reported resident to resident abuse. The incident report identified a staff witnessing resident #021 have an identified responsive behaviour towards resident #022 in an identified area of the home on an identified date and time. The incident was not reported to the Director until the next day in the evening.

Interview with the DOC confirmed the home did not immediately notify the Director of the incident. [s.24. (1)] (606)

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

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

The licensee failed to ensure the planned menu items are offered and available at each meal and snack.

Review of CI report made to the MOHLTC on an identified date, revealed an incident of staff to resident abuse/neglect related to resident #010.

The incident report indicated on an identified date, resident #010 entered the dining room at lunch after the first course had been served and was not offered the first course.

Resident interview revealed that he/she arrived to the dining room after soup was served and was only offered an entrée and dessert choice and not soup. Resident revealed he/she felt upset that no one noticed or offered him/her soup, including PSW #140 who had served his/her entrée.

Record review of resident's plan of care and interviews with staff #165, #164 and #166 revealed that resident #010 is known to staff to accept and enjoy soup in a mug along with taking half an entrée course.

Menu review identified soup as part of the planned menu at lunch on the identified date.

Interviews with dietary and PSW staff #140, #170 and #166 identified that one staff member usually served soup and when a resident arrives late to the dining room that soup should still be offered by any staff member that notices the late arriving resident.

An interview with the food services manager confirmed that soup was part of the menu planned and should have been offered to resident #010. [s. 71. (4)] (110)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substituted decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected, or witnessed incident of abuse or neglect of the resident.

Review of a CI report submitted to the MOHLTC on an identified date, reported an incident of resident to resident abuse.

The incident report identified a staff witnessing resident #021 have an identified responsive behaviour towards resident #022 at an identified time and place.

Interview with the SDM revealed he/she spoke to resident #022 after the incident happened and observed resident to be upset and verbalized to him/her that he/she was afraid of resident #021.

The SDM stated the home did not notify him/her of the incident until the day after when he/she visited resident #022.

Interview with the DOC confirmed the SDM was not notified of the incident until one day after the incident. [s. 97. (1) (b)] (606)

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee failed to ensure when making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident, in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident.

Review of CI report submitted to the MOHLTC on an identified date, reported an incident of staff to resident abuse.

Review of the home's investigation revealed PSW #148 and #149 were present and responded to the incident. Review of the amended CI, revealed the names of PSW #148 and #149 were not included in the report.

Interview with the DOC revealed he/she was not aware that this was a legislative requirement and confirmed that PSW #148 and #149's names were not included in the amended report. [s. 104. (1) 2.] (606)

Issued on this 27th day of February, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), JANET GROUX (606), JOVAIRIA AWAN (648), KAREN MILLIGAN (650), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2016_414110_0008
Log No. / Registre no:	023719-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
Licensee / Titulaire de permis :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
LTC Home / Foyer de SLD :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kyla MacDonald

To MILL CREEK CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 19. (1). to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff as follows:

1. Protect residents from abuse by implementing a process to monitor, assess, and identify residents exhibiting responsive behaviours.
2. To ensure that different approaches are attempted to manage residents' with responsive behaviours when the current approaches are not effective.
3. Re-educate and train all staff on:
a. the home's zero tolerance of abuse and neglect policy
b. identifying forms of resident to resident and staff to resident abuse and staff to resident neglect.
4. Monitor and audit staff compliance to the home's policy.
The plan should identify who will be responsible for completing all of the tasks identified in the order and the timeline in which the plan will be implemented.

The plan shall be submitted to inspector Janet Groux by March 15, 2017 via email at Janet.Groux@ontario.ca

Grounds / Motifs :

1. Review of a Critical Incident (CI) report submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date revealed an allegation of resident to resident abuse.

The incident report identified that resident #074 had an identified responsive behaviour towards resident #075 while resident #075 was walking back to his/her room in a hallway without resident #075's consent.

Record review of resident #075's progress note on an identified date, revealed resident #075 reported the unwitnessed incident to his/her POA. Resident #075's POA called the home on an identified date and time and notified RPN #136 of the reported incident. The POA reported to RPN #136 that resident #074 identified responsive behaviour towards resident #075. The progress note further revealed resident #075 expressed his/her upset about the incident and was scared to go to bed.

Record review of resident #074's written care plan, identified that he/she was known to have identified responsive behaviours. Resident #074's care plan further identified the need for safety checks related to the identified responsive behaviour between resident #074 and co-residents.

Interview with resident #075 reiterated the incident as described above, identifying resident #074 with the identified responsive behaviour. Resident #075 identified the incident as abuse, and expressed that he/she had felt fear and distress due to the incident. Interview with the Administrator confirmed the incident was determined to be abuse.

The licensee failed to protect resident #075 from abuse by anyone in the home. [s. 19. (1)]

(648)

2. Review of a CI submitted on an identified date revealed an incident of resident to resident abuse.

Review of resident #021's progress notes revealed the resident was identified with identified responsive behaviour towards staff and other residents.
.
Interviews with PSW #112 and RPN #118 revealed resident #021 was identified with responsive behaviours and confirmed that resident #021 was observed with these behaviours towards resident #022 on the identified date and that staff were not able to intervene until after the incident occurred.

The licensee has failed to ensure resident #022 was protected from abuse by anyone. [s. 19. (1)]
(606)

3. Review of a CI reported submitted on an identified date, revealed a incident of resident to resident abuse.

Review of resident #024 and #025's progress notes identified that a staff member observed resident #024 in resident #025's room with an identified responsive behaviour towards resident #025.

Review of resident #025's progress notes indicated PSW #130 witnessed resident #024 in resident #025's room and reported that resident #024 had an identified responsive behaviour towards resident #025.

Interview with PSW #130 revealed he/she witnessed the incident as mentioned above and removed resident #024 away from resident #025. He/she indicated resident #025 was observed to be visibly upset at what had happened and he/she calmed and reassured the resident.

Interviews with NM #143 revealed resident #024 had a history of identified responsive behaviours towards other residents and confirmed this was the first incident that resident #024 had a responsive behaviour of this type towards another resident. [s. 19. (1)]

(606)

4. Review of a CI report submitted the MOHLTC on an identified date, revealed an incident of resident to resident abuse.

Review of the home's internal incident report and progress notes on an identified date indicated resident #017 approached resident #018 in a hallway and had an identified responsive behaviour towards resident #018. Resident #018 sustained an injury.

Interviews with PSW #103, RPN #104 revealed they were the staff who responded to the above incident between resident #017 and resident #018. They revealed resident #017 as having responsive behaviours and had previous incidents of an identified responsive behaviour towards another resident prior to the incident with resident #018. They stated they responded immediately to the incident and had removed resident #017 away from resident #018.

Interview with ADOC #105 confirmed resident #018 sustained an injury as a result of the incident.

The licensee failed to protect resident #018 from physical abuse by anyone in the home [s. 19. (1)]

(606)

5. Review of a CI report submitted to the MOHLTC on an identified date revealed an allegation of resident to resident abuse.

The incident report identified resident #070 with responsive behaviours, as witnessed by RPN #127. The report identified the incident occurred in the common area of an identified home area on an identified date. Resident #071 was in the common area when resident #070 approached resident #071 and had an identified responsive behaviour. Resident #070 sustained an injury.

Record review of resident #071's progress notes on an identified date revealed documentation of the incident as described in the CI report. Documentation revealed that resident #071 was consoled; his/her injury addressed and monitoring was initiated.

Record review for resident #070 revealed he/she was assessed for responsive behaviours on an identified date, following the incident reported. The responsive behaviour assessment indicated an identified threat level risk and that resources in the home for behaviour management had been contacted for follow up.

Further record review of resident #070's progress notes identified he/she continued to exhibit responsive behaviours directed to staff and other residents on multiple occasions, following this reported incident.

Interview with resident # 071 reported that he/she was shaken up by the altercation with resident #070.

Interview with RPN #127 revealed he/she had responded to the altercation which was witnessed by staff and residents. RPN #127 was unable to confirm the identities of the witnessing staff and residents present at the time of the

incident. Interview with RPN #127 confirmed the altercation as noted in the progress notes reviewed. RPN #127 reported routine checks were initiated for resident #070, and resident #071 was assessed for the fall.

Interview with the Administrator confirmed the home determined the incident as resident to resident abuse. The licensee failed to protect resident #071 from abuse by anyone in the home. [s. 19. (1)]

(648)

6. Review of a CI report submitted to the MOHLTC on an identified date revealed an allegation of staff to resident abuse.

Review of the CI report revealed PSW #148 inappropriately responded to resident #035's when resident reached out to the PSW. The CI further indicated that upon assessment, resident #035 sustained an injury.

Review of resident #035's progress notes revealed resident was cognitively impaired and had identified responsive behaviours.

Review of resident #035's plan of care indicated resident had behavioural symptoms related to his/her identified medical diagnosis. The plan of care identified interventions to manage his/her behaviours.

Interview with PSW #120 revealed that he/she witnessed the incident and confirmed he/she saw PSW #148 inappropriately responded to resident #035 when resident #035 reached out to PSW #148. Interview with PSW #149 revealed he/she was nearby and heard PSW #148's inappropriate response to resident #035's responsive behaviour. They indicated this behaviour was considered unacceptable and abusive. They indicated resident #035, who was cognitively impaired, was upset about the incident.

Interview with PSW #148 revealed he/she denied that he/she abused resident #035.

Interview with the DOC revealed PSW #148's behaviour towards resident #035 was unacceptable.

The licensee failed to protect resident #035 from abuse by anyone in the home. [s. 19. (1)]

The severity of this non compliance is actual harm or risk. The scope is isolated and the home has a history of non compliance in this area issued during inspection 2014_369153_0002 of May 26, 2014. (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 13, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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