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

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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
Oct 3, 2016	2016_332575_0016	017973-16	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St. NORTH BAY ON P1B 6J4

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

CASSELLHOLME
400 OLIVE STREET NORTH BAY ON P1B 6J4

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

LINDSAY DYRDA (575), MARIE LAFRAMBOISE (628), SYLVIE LAVICTOIRE (603)

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): July 4-8 and 11-14, 2016

Additional logs inspected during this RQI include:

A Follow-Up log, related to two previous compliance orders (CO) issued on January 13, 2016 from inspection #2015_336620_0009, with a compliance date of February 5, 2016. CO #001 related to doors in the home and CO #002 related to food temperatures;

Three critical incidents submitted by the home related to resident to resident abuse;
Five critical incidents submitted by the home related to allegations of staff to resident abuse;
One critical incident submitted by the home related to a resident fall;
One complaint submitted to the Director related to housekeeping and laundry in the home;
Two complaints submitted to the Director related to allegations of staff to resident abuse;
One complaint submitted to the Director related to privacy in treatment; and
One complaint submitted to the Director related to a resident's responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Vice President of Clinical Services (VPCS), Manager of Clinical Standards (MCS), Manager of Infection Control (MIC), Medical Director (MD), Human Resources Director, Registered Dietitian (RD), Manager of Housekeeping and Laundry (MHL), Manager of Maintenance, Manager of Activities, Director of Operations, Resident Assessment Instrument (RAI) Coordinator, Resident Coordinator, Scheduling Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Housekeeping staff, Behavioural Supports Ontario (BSO) staff, family members, and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **8 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #002	2015_336620_0009	628

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-resident areas were locked to restrict unsupervised access to those areas by residents when they were not being supervised by staff.

During inspection #2015_336620_0009 completed December 2015, a compliance order (CO) was issued pursuant to O. Reg 79/10, s. 9. (1) 2. The compliance order was issued on January 13, 2016, with a compliance date of February 5, 2016. Part of the compliance order required the home to ensure that all staff were trained related to which doors of the home were to be kept locked, how locking devices were to be activated, and that a record of this training was maintained.

On July 4, 2016, during the initial tour of the home, Inspector #628 observed two mechanical doors on the third floor residential unit unlocked. The mechanical rooms contained an electrical panel and mechanical equipment. In one unit, the shower door had a sign that required the room to be locked and was observed unlocked. Upon further observation, the Inspector noted that a component of the lock appeared to be missing. The Inspector asked PSW #136 about the door, and they attempted to lock the door, however, they were unable to. The PSW stated they would contact the maintenance department.

During an interview with the Inspector, Maintenance staff member #123 stated that all staff had not received training regarding which doors of the home were to be kept locked and how locking devices were to be activated.

During an interview with the Inspector, the Manager #102 provided the Inspector with the record of training that only included housekeeping staff. Manager #102 stated that all staff had not been trained as required in the previous order. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and neglect by the licensee or staff.

1. a) Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in April 2016, regarding alleged staff to resident abuse. The CI report indicated that while investigating a staff to staff complaint regarding allegations of bullying, it was reported by Dietary staff #110 that approximately two weeks prior, they witnessed PSW #107 scold resident #018 in a loud, condescending manner. The home's investigation substantiated the allegations, and PSW #107 received disciplinary action for emotional abuse towards resident #018.

In addition, the investigation revealed a second incident reported by PSW #117 that occurred in March 2016. The second incident indicated that PSW #107 was condescending and belittling to resident #018. The investigation notes indicated that PSW #117 advised RN #118 about concerns involving PSW #107 and resident #018. RN #118 did not report the suspicion.

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

During an interview with the Inspector, Dietary staff #110 stated that they did not report the incident they observed involving PSW #107 and resident #018 as timely as they should have.

b) Inspector #575 reviewed a CI report submitted to the Director on a certain date in July 2016, regarding alleged resident to resident abuse. The CI report indicated that resident #018 reported to RN #103 that resident #032 sexually assaulted them. The CI report further indicated that resident #018 reported this to staff one week prior, and that the incident was not reported to police until the day after the CI report was filed in July 2016.

The resident's progress notes were reviewed by the Inspector. Progress notes on three occasions in June and July 2016, indicated that the resident had told staff that resident #032 sexually assaulted them. One note in June 2016 was recorded by an RPN, and two notes from July 2016, were written by PSWs, however, they indicated that the RPN was

aware.

During an interview with the Inspector, Manager #108 stated that the RPNs should have reported the allegations to the RN, but did not.

The home's policy titled, 'Abuse, Neglect and Retaliation Prevention', last revised December 14, 2015, indicated that all residents had the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times. Staff must immediately report to their supervisor all suspected, alleged, or witnessed incidents of resident abuse or neglect. The supervisor would then follow procedures for initiating an investigation, which included notifying the police of an incident that would constitute a criminal offence.

According to the LTCHA, 2007, s. 20. (1), 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. The two incidents of alleged staff to resident abuse involving PSW #107 toward resident #018 were not immediately reported to the supervisor. The incident of alleged resident to resident abuse involving resident #032 toward resident #018 was not reported to the supervisor, an investigation was not started, and the police were not immediately notified of an incident that would have constituted a criminal offence. During these incidences, the home's policy was not complied with, five times.

2. a) Inspector #575 reviewed an anonymous complaint submitted to the Director in May 2016. The complaint indicated that on a day in May 2016, PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident in May 2016, involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They

stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their mind. No report was submitted to the Director.

b) Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an alleged staff to resident abuse. The CI report indicated resident #015 advised RN #130 that PSW #131 was rough when providing care. The CI report indicated that PSW #131 had previous history of discipline related to improper resident care.

On February 12, 2015, a memo was sent to all Long-Term Care Home Licensee's and Administrator's outlining the mandatory CI reporting requirements. The memo outlined that after hours (Business hours: Monday to Friday 0830 hours to 1630 hours), staff are to call the After Hours Pager.

During an interview with Manager #102, they stated that PSW #131 was previously disciplined in 2014 for providing improper care to another resident. Manager #102 indicated that all RN's were aware of the PSW's previous history and were advised to monitor this staff member. Manager #102 confirmed the incident was reported to the RN on a certain day in May 2016 and was not reported to the Director until the following day.

During an interview with Manager #108, they stated that the RN should have reported the alleged abuse by calling the After Hours Pager when they became aware.

c) Inspector #603 reviewed a CI report submitted to the Director in April 2016. The CI occurred three days prior, when resident #013 was found on the floor in the hallway. Resident #027 was near the resident and claimed that they pushed resident #013 to the floor. Resident #013 sustained an injury.

Inspector #603 interviewed Manager #108 and they did not know the reason why it was reported three days after the incident occurred. Manager #108 explained that it was the home's expectation that if an incident occurred after hours, the RN Supervisor was to report the incident to the Director immediately.

According to the LTCHA, 2007, s.24 (1) 2, a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon with it is based to the Director. The incidents of alleged staff to resident abuse involving PSW #134 toward resident #031, PSW #131

toward resident #015 and one incident of alleged resident to resident abuse involving resident #027 toward resident #013, were not immediately reported to the Director.

3. Inspector #575 reviewed an anonymous complaint submitted to the Director in May 2016. The complaint indicated that PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their mind. No immediate investigation was completed in regards to this incident.

According to the LTCHA, 2007, s. 23. (1) (a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. The incident of alleged staff to resident abuse involving PSW #134 toward resident #031 in May 2016, was not investigated.

4. Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an allegation of staff to resident verbal abuse. The CI report indicated that Housekeeping Aide #124, yelled at resident #021 in a forceful tone, to leave a certain area of the home.

The same day the CI report was submitted, the Central Intake Assessment and Triage Team (CIATT) Inspector advised the home to update the CI report with any previous concerns related to Housekeeping Aide #124, the outcome of the investigation and a long-term plan of action to prevent recurrence.

The CI report was amended three days later and indicated that the long-term actions would be determined after the investigation was completed. Two days later a note was

entered into the "General Notes" section of the CI, and indicated that the investigation was completed; however, no long-term actions were included.

During an interview with Manager #115, they stated to the Inspector that they must have missed that section of the CI report, and that they would update the report to include the long-term plan of action.

According to O. Reg. 79/10, s. 104 (1) 4., every licensee of a long-term care home shall ensure that the report to the Director includes the long-term actions planned to correct the situation and prevent recurrence. The incident of alleged staff to resident verbal abuse involving Housekeeping Aid #124 toward resident #021 was not updated to include the long-term plan of action.

5. Inspector #575 reviewed the home's policy titled, "Abuse, neglect and Retaliation Prevention" last revised December 14, 2015. On page 3, under the heading 'CIS Mandatory Reporting under Section 24(1) of the LTCHA', the description stated that under section 24, "certain persons" were required to make an immediate report to the Director.

Section 20 (2) (d) of the LTCHA, specifically, mandates that the licensee's policy contains an explanation of the duty under s. 24 to make mandatory reports. The licensee's policy did not explain the duty to make mandatory reports under s. 24 because it failed to explain:
-that "a person," which includes a staff member, has a duty to report under s. 24, irrespective of the licensee's duty. [s. 19.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During stage one of the inspection, it was identified during the census review that resident #012 had an unplanned weight loss at a rate in excess of regulatory limits.

Inspector #603 reviewed resident #012's physician orders and noted that a specific interventions was ordered for an existing skin wound.

The Inspector interviewed resident #012, who explained and demonstrated that they had a skin wound and it had been covered with a dressing.

The Inspector interviewed RPN #109, who confirmed that resident #012 had a skin wound needed regular dressings.

The Inspector reviewed resident #012's current care plan, which had no focus or intervention for a skin wound. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care was provided to the resident as specified in the plan.

During stage one of the inspection, it was identified during the census review that resident #012 had an unplanned weight loss at a rate in excess of regulatory limits.

Inspector #603 reviewed resident #012's physician orders and noted that a supplement was ordered for an existing skin wound. The Inspector reviewed the resident's progress notes which indicated that the resident did not receive the supplement on two occasions in July 2016.

The Inspector interviewed RPN #109, who explained that resident #012 did not receive the supplement on the two specific occasions because they were short staffed on the specific unit and RPN #109 did not have time to get it.

The Inspector interviewed the Registered Dietitian (RD) who explained that the supplement was available on the day it was not provided. [s. 6. (7)]

3. During stage one of the inspection, Inspector #575 observed resident #008 with altered skin integrity.

During an interview with Manager #108, they stated that when staff notice skin integrity issues, they are to fill out an incident report for any new alteration in skin integrity.

The resident's plan of care indicated an intervention that staff were to report any redness, or change in skin integrity to Registered staff.

The Inspector reviewed the resident's health care record and did not find an incident report related to the resident's altered skin integrity.

During an interview with the Inspector, RN #106 stated that an incident report was not completed for resident #008's altered skin integrity. The RN stated that there should have been one. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the inspection, it was noted by Inspector #575 that resident #008 had altered skin integrity. Three days later, the Inspector observed a dressing to an area of the resident's body.

The Inspector reviewed the resident's plan of care. In the resident's care plan, under the focus related to skin integrity, an intervention dated April 2016, indicated that the resident had altered skin integrity to a specific area of their body (a different area than observed by the Inspector) and staff were to apply a dressing. In the resident's health care record, the Inspector noted a completed weekly wound assessment, that indicated the wound was healed six days after the intervention was implemented. In addition, the resident's care plan under the focus for transferring, included an intervention for staff to apply an assistive aide on the resident to prevent altered skin integrity. During interviews with staff (PSW #104 and #116), they stated that the resident did not use the assistive aide and that the care plan was not updated.

During an interview with the Inspector, RPN #105 stated that the wound to the specific area of the resident's body was healed, however, the care plan was not updated. The RPN was not aware if the resident used the assistive aide during transferring, and stated that it was something that could be implemented. The RPN stated that they would update the care plan. [s. 6. (10) (b)]

5. Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an allegation of staff to resident verbal abuse. The CI report indicated that Housekeeping Aide #124, yelled at resident #021 in a forceful tone, to leave a certain area of the home.

The home's internal investigation indicated that abuse did not occur; however, Housekeeping Aide #124 acknowledged that when they repeated their request for the resident to leave a certain area of the home, they did so in a raised voice.

The Inspector reviewed the resident's plan of care. Under the responsive behaviour focus, one intervention indicated that staff were to talk with the resident in a low pitch, calm voice to decrease or eliminate behaviours; however, a second intervention indicated that staff were to speak in a raised voice because the resident was hard of hearing.

During an interview with the Inspector, RN #121 stated that staff were to speak in a low pitch voice with resident #021 because the resident would get agitated if staff were to

raise their voice. The RN stated that the intervention regarding staff to raise their voice might have been from admission, and that they would update the care plan to reflect the current needs of the resident. [s. 6. (10) (b)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan of care had not been effective.

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in April 2016. The CI occurred three days prior, when resident #013 was found on the floor. Co-resident #027 was near resident #013 and stated that they had pushed resident #013 to the floor. Resident #013 sustained an injury.

The Inspector reviewed resident #027's current care plan, which included a focus for certain responsive behaviours. The interventions included to have a specific device across their doorway.

During the inspection, the Inspector observed resident #027's room which did not have a specific device across their doorway.

The Inspector interviewed RPN #109 who confirmed that there was no specific device utilized for the resident's doorway, and that it should not have been in the resident's care plan as it was not an effective intervention. [s. 6. (10) (c)]

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 ensuring that resident #008 and #021 are reassessed and the plans of care are reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During the inspection, Inspector #603 observed RPN #101 administer insulin to resident #022. RPN #101 did not prime the insulin pen before giving the insulin.

The Inspector interviewed RPN #101, who explained that they did not prime the insulin pen before administering it to the resident. RPN #101 also explained that they were not aware of what the home's expectation was or what the policy consisted of; however, they did confirm that priming an insulin pen was "best practice".

The Inspector reviewed the home's policy titled, "How to Administer Insulin #3-12", last revised January 2014, which indicated that as part of the procedure, the nurse was to "prime the needle by dialing 2 units of insulin on dial and pressing down on injection button. The nurse should see a drop of insulin on the tip of needle. If there is no drop of insulin visible then repeat again until a drop appears". [s. 8. (1) (b)]

2. During the inspection, Inspector #628 observed resident #009 with altered skin integrity.

Eight days later, the Inspector reviewed resident #009's the health care record. No skin and wound assessments were noted.

The Inspector reviewed the home's policy titled, "Reporting Resident Incidents – Procedure #R18.5.0", last revised November 5, 2016. The policy provided procedures for staff to follow when resident's had incidents of responsive behaviours, unsafe exiting,

smoking accidents and abrasions/bruising or skin tears. The home's procedure required any staff member who witnessed or discovered the incident, to inform a registered staff member immediately, then complete the Resident Incident Report and document the investigation.

The Inspector interviewed RPN #126, who verified that resident #009 had altered skin integrity and the incident was not documented.

The Inspector interviewed Manager #108, who verified that the staff did not follow the home's expected procedure of completing an Resident Incident Report and should have completed the incident report regarding resident #009's altered skin integrity. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policies titled, "How to Administer Insulin #3-12" and "Reporting Resident Incidents – Procedure #R18.5.0" are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication response system could be easily seen, accessed, and used by residents, staff and visitors at all times.

On three occasions, Inspector #603 observed resident #003 in bed and their call bell was dangling on the floor, at the back of the head board, and not accessible by the resident.

One one occasion, Inspector #575 observed resident #026's washroom and noted that the call bell string was missing and the call bell was not working. Seven days later, Inspector #603 observed the same findings.

Inspector #603 interviewed attending PSW # 120 who explained that resident #003 was capable of ringing their call bell. RPN #109 explained that resident #026 not able to ring the call bell. RPN #109 confirmed that the call bell's string was missing from resident #026's washroom and they were able to pull on the black button engaging the call bell, but with great difficulty. The RPN stated that call bell's string should have been in place to ensure safety for all.

Inspector reviewed the home's policy titled, "Monitoring Physically/Cognitively Impaired Residents - Call Bell System - Resident 24 hour" #08.0, last revised December 11, 2015,

which identified that staff monitor cognitively or physically impaired residents who are unable to use a call bell system for accessing staff when the residents are in bed. If the residents are identified as being cognitively impaired or physically disabled, the staff will bundle the call bell, complete the "Call Bell Assessment Tool" and will do hourly checks to ensure safety. The policy indicated that when the call bell is bundled, it must be easily seen, accessed and used by residents, staff and visitors at all time. It must not be removed or replaced by "plugs".

In this case, the call bells were not easily accessible. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available at each bed, toilet, bath and shower location used by residents.

During stage one of the inspection, Inspector #575 observed resident #026's call bell missing at the bedside. The call bell had been replaced by a plug.

Inspector #603 interviewed RPN #109 who confirmed that resident #026's call bell was missing at their bedside and the outlet had been plugged. RPN #109 explained that the resident was not able to ring the call bell, the call bell at the bedside should have been bundled and not plugged as per policy.

Inspector #603 reviewed the home's policy titled, "Monitoring physically/Cognitively Impaired Residents Call Bell System – Resident 24 hour" #08.0, last revised December 11, 2015. The policy indicated that when the call bell is bundled, it must be easily seen, accessed and used by residents, staff and visitors at all time. It must not be removed or replaced by "plugs". [s. 17. (1) (d)]

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 ensuring that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times and that is available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

WN #6: 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).

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

Findings/Faits saillants :

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

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in April 2016, regarding alleged staff to resident abuse. The CI report indicated that while investigating a staff to staff complaint regarding allegations of bullying, it was reported by the Dietary staff #110 that approximately two weeks prior, they witnessed PSW #107 scold resident #018 in a loud, condescending manner.

The home's investigation substantiated the allegations, and PSW #107 received disciplinary action for emotional abuse towards resident #018. In addition, the investigation revealed a second incident reported by PSW #117, that occurred March 2016. The second incident indicated that PSW #107 was condescending and belittling to resident #018. The investigation notes indicated that PSW #117 advised RN #118 about concerns involving PSW #107 and resident #018. RN #118 did not report the suspicion.

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

During an interview with the Inspector, Dietary staff #110 stated that they did not report the incident they observed involving PSW #107 and resident #018 as timely as they should have. [s. 20. (1)]

2. Inspector #575 reviewed a CI report submitted to the Director in July 2016, regarding alleged resident to resident abuse. The CI report indicated that resident #018 reported to RN #103 that resident #032 sexually assaulted them. The CI report further indicated that resident #018 reported this to staff one week prior, and that the incident was not reported to police until one day after the report was submitted.

The resident's progress notes were reviewed by the Inspector. Progress notes on three occasions in June and July 2016, indicated that the resident had told staff that resident #032 sexually assaulted them. One note in June 2016 was recorded by an RPN, and two notes from July 2016, were written by PSW's, however, they indicated that the RPN was aware.

During an interview with the Inspector, Manager #108 stated that the RPNs should have reported the allegations to the RN, but did not.

The home's policy titled, 'Abuse, Neglect and Retaliation Prevention', last revised December 14, 2015, indicated that all residents had the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times. Staff must immediately report to their supervisor all suspected, alleged, or witnessed incidents of resident abuse or neglect. The supervisor would then follow procedures for initiating an investigation, which included notifying the police of an incident that would constitute a criminal offence. [s. 20. (1)]

3. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

Inspector #575 reviewed the home's policy titled, "Abuse, neglect and Retaliation Prevention" last revised December 14, 2015. On page 3, under the heading 'CIS Mandatory Reporting under Section 24 (1) of the LTCHA', the description stated that under section 24, "certain persons" were required to make an immediate report to the Director.

Section 20 (2) (d) of the LTCHA, specifically, mandates that the licensee's policy contains an explanation of the duty under s. 24 to make mandatory reports. The licensee's policy did not explain the duty to make mandatory reports under s. 24 because it failed to explain:
-that "a person," which includes a staff member, has a duty to report under s. 24, irrespective of the licensee's duty. [s. 20. (2) (d)]

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 ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was 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.

Inspector #575 reviewed an anonymous complaint submitted to the Director in May 2016. The complaint indicated that PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their mind.

No immediate investigation was completed in regards to this incident. [s. 23. (1) (a)]

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 ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported, of abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations, is immediately investigated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #575 reviewed an anonymous complaint submitted to the Director in May 2016. The complaint indicated that on a day in May 2016, PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident in May 2016, involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their mind. No report was submitted to the Director.
[s. 24.]

2. Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an alleged staff to resident abuse. The CI report indicated resident #015 advised RN #130 that PSW #131 was rough when providing care. The CI report indicated that PSW #131 had previous history of discipline related to improper resident care.

On February 12, 2015, a memo was sent to all Long-Term Care Home Licensee's and Administrator's outlining the mandatory CI reporting requirements. The memo outlined that after hours (Business hours: Monday to Friday 0830 hours to 1630 hours), staff are to call the After Hours Pager.

During an interview with Manager #102, they stated that PSW #131 was previously disciplined in 2014 for providing improper care to another resident. Manager #102 indicated that all RN's were aware of the PSW's previous history and were advised to monitor this staff member. Manager #102 confirmed the incident was reported to the RN on a certain day in May 2016 and was not reported to the Director until the following day.

During an interview with Manager #108, they stated that the RN should have reported the alleged abuse by calling the After Hours Pager when they became aware. [s. 24. (1)]

3. Inspector #603 reviewed a CI report submitted to the Director in April 2016. The CI occurred three days prior, when resident #013 was found on the floor. Resident #027 was near the resident and claimed that they pushed resident #013 to the floor. Resident #013 sustained an injury.

Inspector #603 interviewed Manager #108 and they did not know the reason why it was reported three days after the incident occurred. Manager #108 explained that it was the home's expectation that if an incident occurred after hours, the RN Supervisor was to report the incident to the Director immediately. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the person who has reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if: The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

During the inspection, Inspector #603 observed resident #004's bed to have two full bed rails engaged.

Inspector #603 reviewed resident #004's health care record. The resident's plan of care indicated that the resident used two full bed rails as a Personal Assistance Services Device (PASD) to assist with a routine activity of daily living. The plan of care failed to document a consent for the two full bed rails.

Inspector #603 interviewed RN #121 who explained that resident #004 required two full bed rails while in bed. RN #121 confirmed that there was no consent and explained that one would be completed as soon as possible. [s. 33. (4) 4.]

2. During stage one of the inspection, Inspector #603 observed resident #002 sleeping in bed, with two full bed rails engaged in the guard position.

Inspector #603 reviewed resident #002's health care record. The resident's plan of care indicated that the resident used two full bed rails as a PASD to assist with a routine activity of daily living. The plan of care failed to document a consent for the two full bed rails.

Inspector #603 interviewed RN #121 who explained that resident #002 required two full bed rails. RN #121 confirmed that there was no consent and explained that one would be completed as soon as possible.

Inspector #603 reviewed the home's policy titled, "Restraint & Personal Assistance Service Devices (PASDs) Policy and Procedure # R6.2.0", last revised on July 9, 2015. The policy indicated that an informed consent needs to be obtained for the treatment from the resident and /or the substitute decision maker and the staff are to complete Appendix D "Consent for PASD". [s. 33. (4) 4.]

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 ensuring that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #10: 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 :

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

During the inspection, Inspector #603 observed RPN #101 prepare and administer medication to resident #022 who was on isolation precautions. On the outside of the resident's room, there was a posted sign stating the specific precautions. The signage explained that "hand hygiene is performed before and after each resident contact and gloves are to be worn for direct care". RPN #101 did not wear gloves or wash their hands before or after administrating the medication.

Inspector #603 interviewed RPN #101 who explained that they did not know the reason for resident #022's isolation; however they thought it might have been for a certain infection. RPN #101 also explained that since they did not do any direct care (such as bathing), they did not have to wear gloves; however, they stated that they should have performed hand hygiene.

Inspector #603 reviewed resident #022's health care record which confirmed the certain infection and isolation precautions.

Inspector #603 interviewed Manager #102 who explained that the home's expectation was that all staff, especially the registered staff, should know the reason for isolation precautions in order to determine and communicate the precautions for all, including the members of the public. In the cases of this specific infection, the nursing staff need to assess the situation and determine resident compliance and from this information, the staff will decide on the precautions needed. It was expected that all staff would perform hand hygiene as a minimum requirement while caring for residents in certain isolation.

Inspector #603 reviewed the home's policy titled, "Contact Transmission Precautions Policy #13-1", last revised July 2, 2015, which revealed that in "contact precautions, hand hygiene is to be performed before and after each resident contact" and that all staff are to "maintain routine precautions, at all times". [s. 229. (4)]

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 ensuring that staff participate in the infection prevention and control program, specifically, hand hygiene, to be implemented voluntarily.

WN #11: 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:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included drugs and treatments.

During stage one of the inspection, Inspector #628 noted from the census review that resident #005 received an antipsychotic medication. The census review did not identify a relevant diagnosis.

Inspector #628 reviewed resident #005's health care record. The Inspector noted an "Antipsychotic Evaluation Tool (BPSD)", completed by the Pharmacist. The evaluation noted that the resident did not have a relevant diagnosis while having received the antipsychotic medication. The recommendation was that a decrease in the medication would not change behaviours. The form had a blank area for the physician's signature.

The Inspector reviewed the physician notes and orders for resident #005. No notes regarding review/receipt of the Pharmacist's Antipsychotic Evaluation Tool (BPSD) were noted.

The Inspector interviewed the physician who stated that they had not seen the form and if they did, they would have signed it.

During an interview, Manager #108 confirmed that resident #005 received antipsychotic medication without a relevant diagnosis. They verified that the resident's plan of care should have been based on the interdisciplinary assessment of resident #005, which included the physician. [s. 26. (3) 17.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

During the inspection, Inspector #575 observed (from the hallway) resident #014 in their room at 1100 hours in a wheelchair with a blanket covering their bottom half, however, the resident's legs and brief were exposed. At 1145 hours, the resident was observed being wheeled to the dining room with the blanket covering their bottom half, however, the Inspector noted the resident's brief and legs were visible.

The next day, the Inspector interviewed PSW #104, who stated that the resident required extensive assistance of one staff for dressing, and that the resident preferred to get dressed early. The Inspector indicated to PSW #104 that the resident was observed during the previous day in their wheelchair without bottoms applied. The PSW stated that it was the resident's bath day, they required a "sling bath" and that sling baths were usually done after lunch because they were time consuming. The PSW stated that residents who require sling baths did not get dressed until after their bath was completed.

The Inspector interviewed the resident and a family member. The resident's family member stated that there had been two occasions, including the day of the Inspector's observation, when the resident only had a blanket covering their bottoms until they had their bath. The resident's family member stated that they were disappointed when they arrived to visit the resident prior to lunch because the resident was not dressed and they did not have their bath until after lunch.

The resident's plan of care was reviewed by the Inspector. The care plan indicated that the resident required extensive assistance of one staff for dressing, staff were to pick out appropriate outfits and offer choices, and the goal was for the resident to be appropriately dressed. [s. 40.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the inspection, it was noted by Inspector #575 that resident #008 had altered skin integrity.

Three days later, the Inspector observed a dressing to a certain area of the resident's body.

During an interview with the Inspector, RPN #105 stated that the resident had altered skin integrity to a certain area of their body and a weekly skin assessment was to be completed. The RPN explained and showed the Inspector the Electronic Medication Administration Record (eMAR), which indicated that staff were to change the dressing to the certain area of the resident's body every seven days until healed, and complete the weekly skin assessment form.

The Inspector reviewed the 'Weekly Wound Assessment' record and noted that the date of the initial assessment was in June 2016, and the next assessment was completed two days later. The eMAR was reviewed, and indicated that an assessment was completed a week later, however, the assessment was not documented on the Weekly Wound Assessment record.

The Inspector reviewed the Weekly Wound Assessment record with RPN #105 who confirmed that the weekly assessment was not completed on one occasion and should have been. [s. 50. (2) (b) (iv)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and acting on its results.

Inspector #603 interviewed a member of the Residents' Council, who explained that the licensee did not seek the advice of the Resident Council in developing and carrying out the satisfaction survey.

Inspector #603 reviewed the Resident Council meeting minutes and could not find minutes on sharing the satisfaction survey with the Resident Council in order to seek their advice. On August 27, 2015, it was documented that the satisfaction survey had been sent out and the results would be shared at the next meeting. At the October 29, 2015, Resident Council meeting, the results of the satisfaction survey were shared.

Inspector #603 interviewed the Resident Council's Assistant #100 who confirmed that the home had not shared the satisfaction survey with the Resident Council, prior to sending the letter requesting to complete the attached satisfaction survey to all residents and family members on July 9, 2015. [s. 85. (3)]

WN #15: 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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an allegation of staff to resident verbal abuse. The CI report indicated that Housekeeping Aide #124, yelled at resident #021 in a forceful tone, to leave a certain area of the home.

The same day the CI report was submitted, the Central Intake Assessment and Triage Team (CIATT) Inspector advised the home to update the CI report with any previous concerns related to Housekeeping Aide #124, the outcome of the investigation and a long-term plan of action to prevent recurrence.

The CI report was amended three days later and indicated that the long-term actions would be determined after the investigation was completed. Two days later a note was entered into the "General Notes" section of the CI, and indicated that the investigation was completed; however, no long-term actions were included.

During an interview with Manager #115, they stated to the Inspector that they must have missed that section of the CI report, and that they would update the report to include the long-term plan of action.. [s. 104. (1) 4.]

Issued on this 7th day of October, 2016

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) :	LINDSAY DYRDA (575), MARIE LAFRAMBOISE (628), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_332575_0016
Log No. / Registre no:	017973-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 3, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_336620_0009, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that:

1.) All doors leading to non-resident areas are locked to restrict unsupervised access to those areas by residents when they were not being supervised by staff.

2.) All staff are provided training in relation to which doors of the home are to be kept locked.

3.) Maintain a record of the training including the dates the training was provided and the staff who completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-resident areas were locked to restrict unsupervised access to those areas by residents when they were not being supervised by staff.

During inspection #2015_336620_0009 completed December 2015, a compliance order (CO) was issued pursuant to O. Reg 79/10, s. 9. (1) 2. The compliance order was issued on January 13, 2016, with a compliance date of February 5, 2016. Part of the compliance order required the home to ensure that all staff were trained related to which doors of the home were to be kept locked, how locking devices were to be activated, and that a record of this training was maintained.

On July 4, 2016, during the initial tour of the home, Inspector #628 observed two mechanical doors on the third floor residential unit unlocked. The mechanical rooms contained an electrical panel and mechanical equipment. In one unit, the shower door had a sign that required the room to be locked and was observed unlocked. Upon further observation, the Inspector noted that a component of the lock appeared to be missing. The Inspector asked PSW #136 about the door, and they attempted to lock the door, however, they were unable to. The PSW stated they would contact the maintenance department.

During an interview with the Inspector, Maintenance staff member #123 stated that all staff had not received training regarding which doors of the home were to be kept locked and how locking devices were to be activated.

During an interview with the Inspector, the Manager #102 provided the Inspector with the record of training that only included housekeeping staff. Manager #102 stated that all staff had not been trained as required in the previous order.

The decision to issue this compliance order (CO) was based on the severity of harm which has the potential for actual harm to the safety and well-being of residents. Although the scope of the non-compliance (NC) was identified as isolated, despite previous NC identified as a Written Notification during inspection #2014_283544_0011 and a previous CO during inspection #2015_336620_0009, NC continues with this area of the legislation. (628)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2016

Order # / Ordre no : 002

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. Duty to protect

Order / Ordre :

The licensee shall prepare, submit and implement a plan with a detailed description of what steps the licensee will take to ensure that all residents are protected from abuse by anyone and shall ensure that all residents are not neglected by the licensee or staff.

This plan shall include, but not be limited to:

1.) How the licensee will ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2.) The development and implementation of a system to ensure that that when an allegation of abuse or neglect is reported, that may constitute a criminal offence, the appropriate police force is immediately notified.

3.) How the licensee will ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, is immediately reported to the Director.

4.) How the licensee will ensure that staff immediately report to their supervisor all suspected, alleged or witnessed incidents of resident abuse or neglect as required in the home's policy.

5.) Develop and implement a process to ensure that the report to the Director includes the analysis and follow-up actions, including the long-term actions planned to correct the situation and prevent recurrence.

6.) Review and revise the home's policy to promote zero tolerance of abuse and neglect to include a description of the home's process to ensure that "a person" (i.e. anyone) who has reasonable grounds to suspect any of the mandatory reporting elements have occurred must report the matter to the Director (under the LTCHA).

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133.

This plan must be received by October 18, 2016 and fully implemented by November 14, 2016.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and neglect by the licensee or staff.

1. a) Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in April 2016, regarding alleged staff to resident abuse. The CI report indicated that while investigating a staff to staff complaint regarding allegations of bullying, it was reported by Dietary staff #110 that approximately two weeks prior, they witnessed PSW #107 scold resident #018 in a loud, condescending manner. The home's investigation substantiated the allegations, and PSW #107 received disciplinary action for emotional abuse towards resident #018.

In addition, the investigation revealed a second incident reported by PSW #117 that occurred in March 2016. The second incident indicated that PSW #107 was condescending and belittling to resident #018. The investigation notes indicated that PSW #117 advised RN #118 about concerns involving PSW #107 and resident #018. RN #118 did not report the suspicion.

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

During an interview with the Inspector, Dietary staff #110 stated that they did not report the incident they observed involving PSW #107 and resident #018 as

timely as they should have.

b) Inspector #575 reviewed a CI report submitted to the Director on a certain date in July 2016, regarding alleged resident to resident abuse. The CI report indicated that resident #018 reported to RN #103 that resident #032 sexually assaulted them. The CI report further indicated that resident #018 reported this to staff one week prior, and that the incident was not reported to police until the day after the CI report was filed in July 2016.

The resident's progress notes were reviewed by the Inspector. Progress notes on three occasions in June and July 2016, indicated that the resident had told staff that resident #032 sexually assaulted them. One note in June 2016 was recorded by an RPN, and two notes from July 2016, were written by PSWs, however, they indicated that the RPN was aware.

During an interview with the Inspector, Manager #108 stated that the RPNs should have reported the allegations to the RN, but did not.

The home's policy titled, 'Abuse, Neglect and Retaliation Prevention', last revised December 14, 2015, indicated that all residents had the right to live in a home environment that treats them with dignity, respect, and was free from any form of abuse or neglect at all times. Staff must immediately report to their supervisor all suspected, alleged, or witnessed incidents of resident abuse or neglect. The supervisor would then follow procedures for initiating an investigation, which included notifying the police of an incident that would constitute a criminal offence.

According to the LTCHA, 2007, s. 20. (1), 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. The two incidents of alleged staff to resident abuse involving PSW #107 toward resident #018 were not immediately reported to the supervisor. The incident of alleged resident to resident abuse involving resident #032 toward resident #018 was not reported to the supervisor, an investigation was not started, and the police were not immediately notified of an incident that would have constituted a criminal offence. During these incidences, the home's policy was not complied with, five times.

2. a) Inspector #575 reviewed an anonymous complaint submitted to the

Director in May 2016. The complaint indicated that on a day in May 2016, PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident in May 2016, involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their mind. No report was submitted to the Director.

b) Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an alleged staff to resident abuse. The CI report indicated resident #015 advised RN #130 that PSW #131 was rough when providing care. The CI report indicated that PSW #131 had previous history of discipline related to improper resident care.

On February 12, 2015, a memo was sent to all Long-Term Care Home Licensee's and Administrator's outlining the mandatory CI reporting requirements. The memo outlined that after hours (Business hours: Monday to Friday 0830 hours to 1630 hours), staff are to call the After Hours Pager.

During an interview with Manager #102, they stated that PSW #131 was previously disciplined in 2014 for providing improper care to another resident. Manager #102 indicated that all RN's were aware of the PSW's previous history and were advised to monitor this staff member. Manager #102 confirmed the incident was reported to the RN on a certain day in May 2016 and was not reported to the Director until the following day.

During an interview with Manager #108, they stated that the RN should have reported the alleged abuse by calling the After Hours Pager when they became

aware.

c) Inspector #603 reviewed a CI report submitted to the Director in April 2016. The CI occurred three days prior, when resident #013 was found on the floor in the hallway. Resident #027 was near the resident and claimed that they pushed resident #013 to the floor. Resident #013 sustained an injury.

Inspector #603 interviewed Manager #108 and they did not know the reason why it was reported three days after the incident occurred. Manager #108 explained that it was the home's expectation that if an incident occurred after hours, the RN Supervisor was to report the incident to the Director immediately.

According to the LTCHA, 2007, s.24 (1) 2, a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon with it is based to the Director. The incidents of alleged staff to resident abuse involving PSW #134 toward resident #031, PSW #131 toward resident #015 and one incident of alleged resident to resident abuse involving resident #027 toward resident #013, were not immediately reported to the Director.

3. Inspector #575 reviewed an anonymous complaint submitted to the Director in May 2016. The complaint indicated that PSW #134 was observed to grab a resident by their arm and a nurse advised the staff member to stop, however, they did not.

During an interview with the Inspector, RPN #135 stated that they recalled an incident involving PSW #134. The RPN stated that they were called to a unit in the home to help with a disruptive resident, and when they arrived to the unit the PSW was grabbing resident #031's arm. The RPN stated that they asked the PSW what they were doing, and advised them to stop. The RPN stated that they reported the incident to Manager #108 the next day. The RPN stated that they waited to report to their supervisor because they were not sure if it was abuse or not.

During an interview with the Inspector, Manager #108 indicated that RPN #135 reported the incident to them, however, they did not have any notes regarding the incident. They stated that they did not follow up with PSW #134 until July 2016, and that when it was initially reported to them, abuse did not cross their

mind. No immediate investigation was completed in regards to this incident.

According to the LTCHA, 2007, s. 23. (1) (a), every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. The incident of alleged staff to resident abuse involving PSW #134 toward resident #031 in May 2016, was not investigated.

4. Inspector #575 reviewed a CI report submitted to the Director in May 2016, regarding an allegation of staff to resident verbal abuse. The CI report indicated that Housekeeping Aide #124, yelled at resident #021 in a forceful tone, to leave a certain area of the home.

The same day the CI report was submitted, the Central Intake Assessment and Triage Team (CIATT) Inspector advised the home to update the CI report with any previous concerns related to Housekeeping Aide #124, the outcome of the investigation and a long-term plan of action to prevent recurrence.

The CI report was amended three days later and indicated that the long-term actions would be determined after the investigation was completed. Two days later a note was entered into the "General Notes" section of the CI, and indicated that the investigation was completed; however, no long-term actions were included.

During an interview with Manager #115, they stated to the Inspector that they must have missed that section of the CI report, and that they would update the report to include the long-term plan of action.

According to O. Reg. 79/10, s. 104 (1) 4., every licensee of a long-term care home shall ensure that the report to the Director includes the long-term actions planned to correct the situation and prevent recurrence. The incident of alleged staff to resident verbal abuse involving Housekeeping Aid #124 toward resident #021 was not updated to include the long-term plan of action.

5. Inspector #575 reviewed the home's policy titled, "Abuse, neglect and Retaliation Prevention" last revised December 14, 2015. On page 3, under the heading 'CIS Mandatory Reporting under Section 24(1) of the LTCHA', the description stated that under section 24, "certain persons" were required to

make an immediate report to the Director.

Section 20 (2) (d) of the LTCHA, specifically, mandates that the licensee's policy contains an explanation of the duty under s. 24 to make mandatory reports. The licensee's policy did not explain the duty to make mandatory reports under s. 24 because it failed to explain:
-that "a person," which includes a staff member, has a duty to report under s. 24, irrespective of the licensee's duty.

The decision to issue this compliance order (CO) was based on the severity, scope and compliance history. The severity was determined to have minimal harm or potential for actual harm to the health, safety and well-being of residents. The scope was determined to be a pattern of inaction, affecting a total of five residents with one resident being affected on several occasions. Non-compliance (NC) was previously issued as a CO in May 2014, during inspection #2014_283544_0011. During inspection #2014_376594_0019, the CO was re-issued in February 2015 and linked to the previous CO. The CO was complied during a follow- up inspection conducted in May 2015 (#2015_281542_0007). Despite previous non-compliance (NC), NC continues with this area of the legislation.

(575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2016

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 3rd day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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