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
Apr 6, 2017	2017_591623_0002	003072-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

SARAH GILLIS (623), KELLY BURNS (554), SAMI JAROUR (570)

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): February 21, 22, 23, 24, 27, 28, March 1, 2, 3, 2017

The following logs were inspected concurrently during this Resident Quality Inspection:
016539-16 - related to alleged physical abuse
026445-16 - related to alleged staff to resident verbal abuse
030335-16 - related to suspected improper care
001370-16 and 003265-17- related to resident to resident physical abuse
003500-17 - related to care issues
034271-16 - Follow-up to CO#001

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Substitute Decision Makers (SDM), Representative of the Residents' Council, the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Recreation Manager, Registered Dietitian, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Housekeeping staff.

In addition, during the course of this inspection, the inspectors toured the home, observed staff to resident and resident to resident interactions, resident social programs, resident meal service, medication administration and infection control practices. The inspectors reviewed clinical health records, staff education records, External Service Education records, Program Evaluations, Medication Management Meeting minutes, Resident Council meeting minutes, family communication news letters, the licensee's investigation documentation, maintenance and repair records and the homes related policies; Medication Incidents, Resident Safety LTC - Personal Assistance Devices, LTC - Least Restraint Program, LTC-Dementia Care Program, Resident Non-abuse Program, Mandatory Reporting of Resident Abuse and Neglect, LTC-Investigation of Abuse and Neglect, Continence care, Management of Concerns, Complaints and Compliments, LTC - Complaints Management, Asbestos and Designated Substances Guidelines, Water Infiltration Procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_346133_0034	623

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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers were identified for resident #030 in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's responsive behaviours.

Resident #030 has a specified medical diagnosis.

Interviews with RPNs #105 and #132 and PSWs #114 and #133 all indicated resident #030 exhibits several identified responsive behaviours towards residents and staff.

A review of the progress notes for a specified four month period, indicated resident #030 exhibited responsive behaviours: towards staff and residents. There were approximately 54 progress notes detailing responsive behaviours exhibited by resident #030 including 6 documented incidents of altercation or aggression toward other residents.

Interview with RPN #105 (BSO RPN) indicated to the inspector that no behaviour triggers were identified in the plan of care for resident #030's behaviours. The resident always liked to have somebody with them and if the resident was not accompanied they would start screaming. RPN #105 further indicated that resident #030 was followed by BSO and that recommendations are provided verbally to staff through huddles and shift reports.

Review of the current plan of care for resident #030 with RPN #105 indicated no triggers were identified for behaviours outlined in the plan of care. The RPN further indicated that no strategies were identified specific to behaviours of verbal and physical aggression and altercation with other residents. The RPN also indicated that Dementia Observation

Scale (DOS) was completed for resident #030, however, the Behavioural Assessment Tool (BAT) was not completed for resident #030 since 2015. RPN #105 indicated the BAT should have been completed for resident #030 to identify the triggers and strategies for exhibited behaviours.

During an interview the DOC indicated to the inspector that when a resident exhibits responsive behaviours, it is an expectation that those behaviours are identified in the plan of care in addition to how to manage those behaviours. If the behaviour escalates, the resident is referred to BSO team, DOS and BAT tools should be completed. The BSO team will come with a plan to manage behaviours and a referral to Ontario Shores is initiated if BSO intervention including medication interventions are not successful.

Review of the current plan of care for resident #030 with the DOC, confirmed the plan of care did not identify triggers and strategies for behaviours specific to verbal or physical aggression and altercation with co-residents. [s. 53. (4) (a)]

2. The licensee failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours, including, reassessment, and alternative interventions.

Related to Intake #001370-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on a specified date, specific to an alleged incident of resident to resident physical abuse, which occurred on a different specified date.

Resident #026 has a specified medical diagnosis. The resident was admitted, to a specified unit of the long-term care home, on a specified date, and was ambulatory on admission, and was able to wander about the resident home area.

Registered Practical Nurse (RPN) #105 , Personal Support Worker (PSW) #116, and the Director of Care indicated (to the inspector) that resident has a known history of exhibiting responsive behaviours, specifically verbal and physical aggression towards co-residents and staff.

The written plan of care (in place at the time of this inspection), related to responsive behaviours exhibited by resident #026, and associated interventions was reviewed.

Registered Practical Nurse #105 and PSW #116 indicated specific identified triggers to

resident #026's responsive behaviours. Both indicated resident #026 was unpredictable, and mood was labile.

Progress notes encompassing a specified period were reviewed (by the inspector), documentation reviewed provided detailed incidences of exhibited behaviours. Resident #026 was eventually transferred to hospital for assessment on a specified date.

On a specified date, the hospital contacted the long-term care home, indicating resident had received a specific medication and was being returned back to the long-term care home.

Registered Practical Nurse, who is on the BSO Team (Behaviour Support) reviewed resident's clinical health record, upon return to the long-term care home and faxed information received to Ontario Shores for future assessments and possible acceptance to Geriatric and Neuropsychiatry Outpatient Services (GNOS).

The following Plan was implemented on a specified date following resident's return from the hospital:
- 24 hour 1:1 staffing and external security guard.
- Relocate to Private (Guest) Suite off of unit for safety of others;
- Meals to be provided in games room, supervised by 1:1 staff. Use of plastic utensils only;
- Specific medication three times daily to commence. Verbal consent, for chemical restraint, received by substitute decision maker. (Note: Signed Consent on file, time of this inspection)

Registered Nurse(s) #110 and #111 were unavailable for interviews during this inspection.

Detailed documentation, by registered nursing staff confirm that on twenty-two (approximate) separate dates resident #026 exhibited verbal and/or physical aggression, and threatened to kill both co-residents and staff. The documentation provides support that resident #026's behaviours escalated and on several dates became volatile, affecting the quality of life for other resident's residing on resident home area. Registered Nursing Staff have documented that interventions, both non-pharmacological and pharmacological, were minimally effective or ineffective. The review of the above documentation failed to support that when interventions were described to be ineffective, that alternative assessments, and or measures/interventions were taken to mitigate risk

to co-residents and or others.

At the time of this inspection, resident #026 had been returned to a private room, on a specific unit. Resident continues to have 1:1 staffing in place on all shifts, with the additional support of an external security guard in place. Resident is no longer ambulatory, is in a wheelchair and is medicated, as per recommendation by Ontario Shores. Resident is currently awaiting further assessment and possible admission to Ontario Shores. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 for each resident demonstrating responsive behaviours, the behavioural triggers for the residents are identified, and strategies are developed and implemented to respond to the resident's responsive behaviours where possible, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and

others who provide direct care to the resident, specific to continence care and bowel care management.

Related to Intake #026445-16, for Resident #028:

Resident #028 has a specific medical diagnosis and is cognitively well. Resident #028 is dependent on staff for activities of daily living.

Resident #028 indicated (to the inspector) that it is his/her preference to be placed onto the toilet, but often is refused by some personal support workers and some make the resident use a bedpan, which is painful.

On a specific date, a written correspondence was forwarded to the Director of Care, by resident's Substitute Decision Maker (SDM #031), specific to the licensee`s policy around toileting during the night, and if resident's were not permitted to use the toilet at night.

The clinical health record, specifically the written care plan was reviewed by the inspector. The plan of care details the following:

- Transfers - requires support due to physical limitations. Interventions include, uses sit to stand lift (SSL) and assistance of two staff.
- Toileting – requires support due to physical limitations. Interventions include, staff to provide full toileting and hygiene needs, toileting schedule at specified times throughout the day, uses SSL for all transfers on and off toilet and commode; refer to Prevail (continence care product) list for required product to be used. Goal of care is, for resident to be clean, dry and odour free.

The licensee failed to ensure that the plan of care, for resident #028, set out clear directions to staff and others who provide direct care to the resident, specific to toileting and continence care between 1800 hours to 0700 hours. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to supervised visits.

Related to Log #016539-16

A Critical Incident Report (CIR) was submitted to the Director under s. 24(1)(2)

Abuse/Neglect on a specified date for an incident involving resident #023.

Review of the progress notes and CIR notes for resident #023 indicated on a specified date and time, PSW #119 reported to RPN #120 that the SDM of resident #023 was hitting the resident on the hands repeatedly and forcing the resident to sit down in a seat at the dining room table. The RPN spoke with the SDM and advised that it was unacceptable to hit the resident and that the resident was not to be forced to sit down. The SDM stated that the resident was biting him/her and it was just a slap on the hand.

The CIR notes indicated interventions were put in place to prevent recurrence including: supervised visits on the unit and that the SDM was no longer able to take the resident out of the building.

The plan of care for resident #023 was updated following the incident and directed the following:
- SDM visits resident on unit with supervision.

Review of the progress notes for resident #023 following the incident indicated:

- On a specific date and time; resident observed to leave the unit with SDM for activities.

- On a specific date and time; resident appeared to be in discomfort; staff noted that resident had swelling to a specified area; resident noted guarding area during assessment; new bruising noted in two identified areas; SDM contacted and informed. As per SDM they both had a fall on a specific date but the SDM did not report the fall to nurse on duty.

- Review the falls incident report that was completed, indicated the resident's SDM witnessed the fall.

On a specific date interview with RPN #105 indicated to the inspector that following the incident on a specified date, resident #023's SDM was encouraged to stay in the unit in the activity room; they were supervised when walking the hallways or sitting in the TV lounge area. The RPN further indicated that there was no constant supervision as the SDM used to take the resident to their room and close the door; staff would knock on the door and ask if everything was ok and then leave the door open; on occasions, the SDM

would leave the unit with the resident without any staff supervision.

On a specified date, interview with PSW #117 indicated to the inspector that they were told at the shift report to be aware that resident #023's SDM not be with the resident unsupervised; PSW further indicated no knowledge if the resident was taken by the SDM to the room or the activity room at the front reception areas.

On a specific date interview with PSW #122 indicated to the inspector that he/she was aware of the incident involving resident #023 being hit by SDM in the dining room; the PSW further indicated that he/she was not aware that resident #023's SDM needed to be supervised while visiting.

On February 28, 2016 during an interview with the DOC, the DOC indicated to the inspector that supervised visit means that staff would monitor the SDM while with resident #023 and also includes that staff monitor if the SDM gets aggressive with the resident and to monitor after the SDM leaves if resident #023 had any bruising.

Review of progress notes and staff interviews indicated no supervision on two documented occasions when the resident was taken by SDM off the unit on an identified date, one day following the incident and on another specified date when the resident sustained a fall with the SDM who did not report the fall to staff until the next day when the resident was found with bruising.

The care was not provided to resident #023 as directed in the plan of care related to supervised visits. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specific to nutrition and hydration.

Related to Intake #003500-17, for Resident #029:

Resident #029 has a specific medical diagnosis. Resident is dependent on staff for activities of daily living. Resident utilizes a wheelchair, and can foot propel. Resident exhibits responsive behaviours, specifically wanders aimlessly about the resident home areas.

Family #032 indicated (to the inspector) that it is his/her belief that resident #029 is not being assisted at meal times. Family #032 indicated that he/she visits three to four times

weekly and when he/she arrives resident is not in the dining room, and wandering the home areas. Family #032 indicated resident requires meal time assistance and is not getting the required assistance, hence resident has lost significant weight during the past six months or more.

Registered Dietician indicated (to the inspector) that resident #029 has been identified as being at high nutritional risk due to specified diagnosis, poor food and fluid intake, significant weight loss and choking. Registered Dietician indicated that resident has been assessed by a Speech Language Pathologist (SLP), that interventions are in place and that the resident is being monitored by SLP and herself at regular intervals or more frequently as indicated by referrals from nursing.

The plan of care for resident #029 was reviewed. The plan of care (includes) and directs the following:

- Eating – requires support of staff for eating and or swallowing. Interventions include, requires set up assistance; requires verbal cueing to continue to eat, pick up food and utensils; follow strategies for safe swallowing as recommended by Registered Dietician and Speech Language Pathologist (SLP); ensure dentures in place before each meal.

- Nutritional Risk "high" – SLP recommendations include, meals to be supervised; ensure resident eats slowly, swallow one amount of food and or liquid before taking more, alternate between taking a bite of food and a sip of liquids through the meal; offer alternate choice (Mac and Cheese) if menu items refused; requires frequent motivation at meals and snacks; provide close supervision at meals and nourishments due to risk of choking; encourage small bites; monitor for any signs of coughing or choking and inform Registered Practical Nurse; encourage food and fluids; offer ice cream at lunch and supper; provide 250 mL at lunch and dinner; provide tea with a little milk; enjoys milk offer 250 mL of cold milk at all meals; sippy cup for all fluids; provide 90 mL of Resource 2.0 with chocolate syrup at lunch and dinner, encourage food first; observe to ensure she drinks the Resource 2.0; if intake is poor, give 90 mL of Resource 2.0 with chocolate syrup as a PRN (as needed).

Registered Practical Nurse (RPN) #125 indicated (to the inspector) that breakfast in the long-term care home is scheduled to begin at 0830 hours.

On March 01, 2017 (at 0830 hours), Resident #029 was not visible (to the inspector) in the dining room for breakfast between the hours of 0830 hours to 0845 hours. Inspector

inquired as to the whereabouts of resident #029, and was told by RPN #125 that resident will not remain seated in the dining area and is most likely wandering about the resident home area. Resident #029 could not be located, by the inspector, on the specific home area, where resident resides; RPN #125 directed inspector to look for resident #029 on another home area on the opposite side of the same floor, indicating resident tends to wander about the entire floor. Resident could not be located by inspector.

Resident was located by Personal Support Worker (PSW) #126, at approximately 0855 hours and brought to the dining room. Resident remained in the wheelchair and seated in the dining room from 0855 hours to 0945 hours; resident made no attempt to leave the table during the observation (by the inspector).

Resident #029 was provided a bowl of cold cereal, a glass of ice water (125 mL) and a glass of milk (125 mL), at approximately 0855 hours; resident began to eat the cereal and would occasionally take a sip of water, without cueing and or encouragement by staff. At 0900 hours, resident was offered a cup of tea by a personal support worker, circulating with the beverage cart. At 0909 hours, a personal support worker placed a plate to the right of resident #029, the plate contained two slices of toast with jam (no crust), scrambled eggs and two orange segments; staff did not make mention of the food plate and or provide any encouragement to the resident. Resident continued to eat the cereal and sip the water. The food plate, containing the toast, eggs and oranges sat untouched for twenty-nine minutes; during this time staff did not approach resident or provide cueing and or encouragement. PSW #126 approached resident (after this period), moved the plate in front of the resident, and handed resident a rolled up slice of toast and walked away; resident took a small bite of the toast and placed it back on the plate. At 0942hours, resident continued to sit at dining room table, the plate containing toast with jam, scrambled eggs and orange segment was left untouched, other than one to two bites taken from one slice of toast. At 0945 hours, resident was observed wandering in the hallway in a wheelchair. On the dining room table was the food plate as earlier described, and a glass of milk (250 ml) not consumed.

During breakfast, resident was observed (by the inspector) to have eaten or drank, ¾ bowl of cold cereal, drank 125 mL of water and a half of a cup of tea.

During the lunch meal on the same date, resident was observed wandering about the dining room holding a sippy cup, containing a milk like substance. Resident was directed back to the table by RPN #125, and provided a meal plate to the resident; the plate contained a peanut butter sandwich (two halves). PSW #126 handed resident a half of

the sandwich, resident accepted and took a bite of the sandwich, then placed the sandwich back onto the plate and left the table. Resident was redirected to the table a second time by Registered Dietician, but did not remain and again wandered off, exiting the dining room. Staff were not observed offering an alternative meal choice, any dessert (specifically ice cream) or additional Resource 2.0 (nutritional supplementation).

During the lunch meal, resident was observed (by the inspector) to eat or drink, a 1/4 of a sippy cup of Resource 2.0 (90 mL) and a bite of a peanut butter sandwich.

Registered Practical Nurse #125, as well at the Registered Dietician indicated that resident routinely is provided 90 ml of Resource twice daily at lunch and supper.

Registered Dietician indicated that resident #029 is to be provided 90 mL of Resource when intake is poor, indicating that this would be in addition to the supplement that the resident already receives twice daily (at lunch and supper). Registered Dietician indicated that it is an expectation that nursing staff follow the plan of care set, especially since resident #029 has lost significant weight, has been identified as failure to thrive and noting the risk of choking.

The care set out in the plan of care was not provided to the resident #029, as specified in the plan, on March 01, 2017, as observed by the following:
- Was not provided cueing to continue to eat, pick up food (other than PSW #126 handing resident a slice of toast once), or to pick up utensils at breakfast;
- Was not provided fluids (beverages) in a sippy cup during the breakfast meal;
- Was not provided Resource 2.0, 90 mL when the breakfast and lunch intake was poorly consumed;
- Was not provided an alternate meal choice at lunch;
- Was not offered ice cream at lunch;
- Interventions of SLP, specifically around chewing and swallowing and consumption of food and fluids, were not implemented by nursing staff or others during this observations, during meals (breakfast and or lunch). [s. 6. (7)]

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

Related to Intake #001370-17, for Resident #026:

Resident #026 has a specified medical diagnosis. Resident is ambulatory and wanders

about the specified unit, where he/she resides.

Registered Practical Nurse (RPN) #105 , Personal Support Worker (PSW) #116, and the Director of Care indicated (to the inspector) that the resident has a known history of exhibiting responsive behaviours, specifically verbal and physical aggression towards co-residents and staff. Registered Practical Nurse #105, PSW #116 and the Director of Care all indicated that the residents mood is labile and behaviours are unpredictable.

Progress Notes reviewed for a specified period of time detail several incidents in which resident #026 is exhibiting verbal and physical aggression and threatening to kill co-residents and staff.

A referral was made by nursing staff to the in-house BSO Team (Behaviour Support) on a specific date. On the same date, Registered Practical Nurse (RPN) #105, who is a member of the BSO Team, visited and assessed resident #026. The Registered Practical Nurse implemented the following plan:
- Initiated DOS (dementia observation system) monitoring
- 1:1 with staff
- Staff informed to not wake resident if sleeping
- Ontario Shores Referral and Medication Review
- Pain monitoring – assess effectiveness of pain medicatio and rule out pain as a trigger

Registered Practical Nurse #105 indicated that the 1:1 staffing was not formalized but being implemented by registered nursing staff.

Progress Notes, on a specific date, provide details that resident #001 and #027 were allegedly abused physically by resident #026. Staff indicated finding resident #026 in resident #001's room, resident was redirected by staff; resident threaten staff stating I will kill them. Resident #001 indicated that resident #026 pulled his/her legs and pushed his/her face into the bed. Resident #001 complained of sore legs. Another resident (#027) indicated resident #026 had choked him/her; RN #111 assessed and found resident #027 to have red marks on his/her neck. Resident #027 indicated resident #026 had twisted his/her leg and foot and hit him/her in the back of the head with his/her fist. Resident complained of discomfort. RN #111 indicated that staff will continue to monitor and that 1:1 staffing remains in place for resident #026.

A second progress note, on a specific dated indicated that resident #026 slowly became aggressive during the night shift, following staff into co-residents rooms, threatening staff,

physically aggressive (kicking, hitting and punching) staff; at one point resident cornered a staff at the nursing documentation center. Staff #112 was injured.

Registered Practical Nurse #111 and Personal Support Worker #112 were unavailable for an interview during this inspection.

Allegations of physical abuse, by resident #026 towards resident #001, #027 and staff, which occurred during the night shifts on two specified dates, were investigated by the management, specifically the Director of Care.

The Director of Care indicated (to the inspector, on March 01, 2017) that the licensee`s investigation concluded, and identified that the assigned 1:1 staff had been distracted and left resident #026 unattended. Director of Care indicated that the 1:1 staff should not have left resident without a staff in constant attendance. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

The licensee's policies, Resident Non-Abuse Program (#ADMIN1-P10-ENT) and Mandatory Reporting of Resident Abuse or Neglect (#ADMIN-010.01) directs the following:
- Revera has a zero tolerance for abuse and neglect.
- Anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.
- Mandatory reporting under LTCHA, section 24 (1) requires a person to make an immediate report to the Director of the Ministry of Health and Long-Term Care if there is a reasonable suspicion that abuse or neglect occurred or may occur as well as the details to support the suspicion.

Related to Intake #026445-16, related to resident #028:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) on a specific date, specific to an alleged incident of staff to resident abuse/neglect. The CIR indicated that resident #028 rang the call bell (resident-staff communication and response system) indicating the need to use the toilet. Resident #028 was told by Personal Support Worker (PSW) #118 to go in his/her brief (continent product). Resident #028 refused and stated they wanted to be put on the toilet. Resident #028 continued to ring the call bell; PSW #118 refused to put resident on the toilet, but did agree to place resident on the bedpan. The alleged abuse-neglect incident occurred on a specified date and time.

The clinical health record, specific progress notes, for resident #028 were reviewed (by the inspector) for a specified time, the review provided details of the following documentation by Registered Practical Nurse(s) (RPN #102 and RPN #121):

- RPN #121 documented on a specific dated and time – during the night shift, resident #028 rang call bell during the shift. Resident indicated to personal support worker (PSW) needing to use the bathroom. PSW told resident that there was no staff to take him/her to the bathroom; resident offered bedpan. Resident refused to use the bedpan and insisted on using the bathroom; resident continued to ring the call bell several times. Resident was upset with PSW who refused to toilet him/her and stated to PSW "I hate you".

- RPN #102 documented on a specific date and time– approached by resident #028 and a private care provider. Resident #028 indicated that he/she had a difficult night with PSW #118. Resident stated PSW #118 was rude and disrespectful to him/her when resident asked to be toileted in the night. Resident told RPN #102 that PSW #118

indicated he/she was alone and unable to toilet him/her. Resident continued to ring the call bell and was at some time placed onto the bedpan. Resident #028 indicated being left on the bedpan, by PSW #118, for a long period of time. PSW re-entered resident's room and rudely stated that resident rang too much. Resident told PSW "I hate you". Resident #028 indicated to RPN #102 that he/she no longer wanted PSW #118 to care for him/her.

Registered Practical Nurse #121 was unavailable during this inspection.

Registered Practical Nurse #102 indicated that it was his/her belief that this incident was reported to the Associate Direct of Care.

Associate Director of Care (ADOC) indicated (to the inspector, March 01, 2017) that he/she was not available to the long-term care home during the specified period of time. ADOC indicated not being aware of the alleged abuse-neglect incident.

Director of Care (DOC) indicated (to the inspector, on March 01, 2016) that RPN #121 did not report the alleged emotional abuse and or neglect to the immediate supervisor, which would have been the Registered Nurse on duty on the date indicated. Director of Care, further indicated that RPN #102 did not report the alleged staff to resident abuse, reported by resident #028 to her (DOC). Director of Care indicated being on-site on the specified date.

Director of Care indicated that both RPN #102 and #121 are aware of the home's zero tolerance of abuse policy and mandatory reporting policy/procedures. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the investigation were reported to the Director related to an incident reported under s. 24(1)(1) involving resident #024.

Related to Log #030335-16

Under O. Reg. 79/10, s. 104 (3), when making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (in 21 days unless otherwise specified by the Director).

The licensee submitted Critical Incident Report (CIR) under s. 24(1)(1) improper/incompetent treatment of a resident that results in harm or risk to a resident, on a specified date for an incident involving resident #024.

Review of the progress notes and CIR notes for resident #024 indicated on a specified date the resident was diagnosed with an undisplaced fracture of a specified area. The incident was reported to the Director two days later.

On February 28, 2016 during an interview with the DOC and the ADOC, both indicated the results of the investigation was not reported to the Director until four months following the incident. [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the results of the investigation for an incident reported under s.24(1)(1) are reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report 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.

Related to Log #030335-16

The licensee submitted Critical Incident Report (CIR) on a specified date under s. 24(1) (1) improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, for an incident involving resident #024. The CIR indicated that resident #024 was observed to have some bruising and swelling to a specific area. Resident #024 was unable to describe how the bruising occurred. The physician ordered for an x-ray to be taken of the area.

Review of the progress notes and CIR notes for resident #024 indicated on specific date the resident was diagnosed with undisplaced fracture of the the specified area.

On February 28, 2016 during an interview with the DOC and the ADOC, both indicated the incident was not immediately reported to the Director.

The incident was reported to the Director two days after a confirmed diagnosis of fracture of unknown cause. [s. 24. (1)]

2. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff, has occurred or may occur and such resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

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

- physical abuse includes, the use of physical force by a resident that causes physical injury to another resident;

- emotional abuse includes, any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by another other than a resident;

- verbal abuse includes, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Under O. Reg. 79/10, s. 5 – For the purposes of the Act and this Regulation, "neglect" is

defined and means the failure to provide a resident with the treatment, care, services or assistance required for health, safety, well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Intake #026445-16, related to resident #028:

Resident #028 has a specified medical diagnosis; he/she is cognitively well. Resident #028 is dependent on staff for activities of daily living, specifically toileting and lifts/transfers, is a sit-stand lift with two staff assisting.

The Director of Care (DOC) submitted a Critical Incident Report on a specific date, specific to an alleged incident of staff to resident abuse/neglect. The CIR indicated that resident #028 rang the call bell (resident-staff communication and response system) indicating the need to use the toilet. Resident #028 was told by Personal Support Worker (PSW) #118 to go in the brief (continent product). Resident #028 refused to go in the brief, and stated they wanted to be put on the toilet. Resident #028 continued to ring the call bell. PSW #118 refused to put resident on the toilet, but did eventually agree to place resident on the bedpan. The alleged abuse-neglect incident occurred on a specific date and an approximate time.

Director of Care indicated (to the inspector, on February 28, 2017) that she first became aware of the alleged staff to resident abuse/neglect incident, on a specific dare at some point after 1000 hours. Director of Care indicated that the incident was reported to her by resident #028.

The Director of Care provided (the inspector) with the home's investigation notes, related to the allegation concerning resident #028. It was noted (by the inspector) that the investigation notes made reference to a written correspondence by resident #028's substitute decision maker (SDM) related to concerns raised regarding the resident's quality of care.

The Director of Care indicated (to the inspector, on March 01, 2017) that she had received written correspondence from resident's SDM on a specific date. The written correspondence by SDM, with a specific date and time, provides the following details:

- Resident #028 called me at 0400 hours in a hell of a state, saying they wanted to go to the bathroom. Resident stated was told (by staff) they couldn't and that they should go in the brief. Resident #028 was mortified that he/she was told to go in the brief; stated

he/she still has self-respect and refused. Substitute Decision Maker indicated receiving a second call from resident that night, stating they had been left to sit on a bed pan for over fifteen minutes. SDM indicated resident has specific medical diagnosis and sitting like that (on a bedpan) for that long is extremely painful and not good. Substitute Decision Maker inquired as to the policy for toileting residents during the night. SDM asked if residents are not allowed to use toilet at night. SDM indicated that Personal Support Worker #118 was the alleged staff identified in this allegation of abuse-neglect.

The licensee failed to report an allegation of staff to resident abuse-neglect (which occurred on a specific date, at approximately 0400 hours). The allegation and information upon which it was based was not reported to the Director until the following day, at 1241 hours.

2. Related to Intake #001370-17, for residents #001, 026 and 027:

The Director of Care submitted a Critical Incident Report (CIR) on a specific date and time, for an alleged incident of resident to resident physical abuse which occurred approximately nine hours earlier. The following are details of the alleged incident:

- Registered Nurse (RN) #111 indicated in a progress note, on a specific date and time, staff reported to RN#111 that resident #026 was found in resident #001's room. Resident #026 was redirected by staff from resident #001's room. Resident #026 stated to staff that he/she would kill them (no indication of who resident #026 was referring to). Resident #001 complained that resident #026 was pulling his/her legs and pushing his/her face into the mattress. Another resident #027, expressed concerns (to staff) that his/her foot and ankle had been twisted by resident #026, and that resident (#026) had hit him/her (resident #027) on the back of the head and neck, using his/her fist. Registered nursing staff assessed residents (#001 and #027), both residents complained of discomfort to their legs, resident #027 had redness on the neck.

Director of Care (DOC) indicated (to the inspector, on February 28, 2017) that Registered Nurse #111 was the RN-Supervisor on shift during the alleged abuse incident. DOC staff, including RN #111, are aware that abuse requires immediate reporting.

Program and Support Services Manager (PSSM), who was the Manager On Call, during the above time period, indicated (to the inspector, on March 01, 2017) that registered nursing staff, from the day shift, notified her of the alleged abuse incidents which had occurred during the night. PSSM indicated that she received the call from registered

nursing staff, believes RN #101, on a specific date and time approximately eight and a half hours after the incident occurred; PSSM indicated it was at that time, she notified the Ministry of the alleged resident to resident abuse, using the after-hours contact number for the Ministry of Health and Long-Term Care. PSSM indicated the Director should have been immediately notified of the alleged physical abuse of residents #001 and #027, by resident #026.

The Director of Care indicated RN #111 is aware that abuse is to be immediately reported to the Director.

The Director was not immediately notified of the alleged resident to resident physical abuse.

Registered Nurse #111 was not available for an interview during this inspection.

3. Related to Intake #003265-17 (and #003500-17), for Resident #029:

The licensee's policy, Mandatory Reporting of Resident Abuse or Neglect (#ADMIN-O10.01) directs that mandatory reporting under LTCHA, Section 24 (1) requires a person to make an immediate report to the Director of the Ministry of Health and Long-Term Care if there is suspicion that abuse or neglect occurred or my occur, as well as the details to support the suspicion.

The Executive Director submitted a Critical Incident Report (CIR), on a specific date and time, for an alleged resident to resident physical abuse incident which had occurred earlier that day. The alleged abuse involved two residents; residents' #029 and #030. The CIR and associated clinical health record review (progress notes) for both residents, provide the following details:

- Registered Practical Nurse (RPN) #102 notified RPN #125 and Registered Nurse-Supervisor (#108) of an altercation between resident #029 and #030. A Personal Support Worker indicated (to RPN #102) that they had witnessed resident #030 pulling his/her walker away from resident #029's legs. Both the Personal Support Worker and RPN #102 indicated hearing screams and went to investigate. Resident #029 sustained injury (to both legs) as a result of the alleged resident to resident abuse incident. Neither residents could recall what precipitated the alleged abuse incident. Resident #030 has a history of exhibiting responsive behaviours, specifically aggression towards other residents and staff. Registered Nursing Staff separate both residents, provided first aid to

resident #029, contacted the physician and contacted police. The On Call Manager was notified by RPN #102 at approximately 1355 hours, on the specified date.

The Executive Director indicated (to the inspector, on March 02, 2017) that she was the On Call Manager on the specified date. Executive Director indicated receipt of the phone call by RPN #102, indicating call came to her at approximately 1355 hours. The Executive Director indicated that she nor registered nursing staff reported the alleged abuse using the after-hours contact number for the Ministry of Health and Long-Term Care, and that the first notification to the Director was the same date at 2216 hours, (approximately eight hours later) when she submitted the CIR.

Executive Director indicated that it was her understanding (and that of Revera's) that the long-term care home has twenty-four hours to report abuse allegations. [s. 24. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program provides for strategies to maximize the resident`s independence, comfort and

ensuring that dignity is fully respected and promoted, including provision of equipment, supplies, devices and assistive aids.

Related to Intake #026445-16:

Resident #028 has a specific medical diagnosis; he/she is cognitively well. Resident #028 is dependent on staff for activities of daily living, specifically toileting and continence care.

The Director of Care (DOC) submitted a Critical Incident Report (CIR) on a specific date, specific to an alleged incident of staff to resident abuse/neglect. The CIR indicated that resident #028 rang the call bell indicating the need to use the toilet. Resident #028 was told by Personal Support Worker (PSW) #118 to go in the brief (continent product).

The Director of Care indicated (to the inspector) that Personal Support Worker #118 indicated that they do not toilet residents on nights due to staffing. PSW #118 indicated (in her witness statement on a specific date, specific to licensee's investigation of CIR) that she and other staff have been directed by management not to toilet residents on nights. The Director of Care denied allegation by PSW #118.

Resident #028 indicated (to the inspector, on March 01, 2017) that he/she has often been told by staff to go in her brief (continence product), and that this was not the first occurrence. Resident #028 indicated that he/she refuses to go in the continence product, but at times, is unable to hold the urge to void and has been incontinent as a result. Resident #028 indicated staff telling him/her to go in the brief is degrading and humiliating.

Resident #028's Substitute Decision Maker (SDM #031) indicated (to the inspector on February 28, 2017) that he/she has heard staff tell resident #028 to go in the brief. SDM indicated it is resident's right to use the toilet when he/she asks. SDM indicated that when staff tell resident #028 to go in the brief, it makes the resident feel as if they are a child.

2. Related to Intake #003500-17:

Resident #029 has a specific medical history, resident requires extensive assistance of staff for all activities of daily living, including toileting and continence care.

Family Member #032 indicated (to the inspector, on February 28, 2017) that resident #029 has asked to use the bathroom, and has been told by staff to go in the brief. Family #032 could not provide specific dates, times or identify staff, but indicated he/she visits at least three to four times weekly during the evening hours and such has occurred on more than one occasion, and has heard nursing staff tell resident #029 to go in the brief.

Resident #029 was not able to recall dates or times when he/she was not toileted by staff and or told to go in the continence product. [s. 51. (1) 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 by ensuring that the continence care and bowel management program provides for strategies to maximize the resident`s independence, comfort and dignity, including equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker (SDM) and

any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse (or neglect) of a resident that, resulted in physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to Intake #001370-17, for resident #001:

Resident #001 has a specific medical diagnosis and resident #001 has a designated substitute decision maker (SDM) for all decisions, including care.

The Director of Care submitted a Critical Incident Report (CIR) on a specific date and time, for an alleged incident of resident to resident physical abuse which occurred on a specific date and time. The following are details of the alleged incident:

- Registered Nurse (RN) #111 indicated in a progress note, that staff reported to RN #111 that resident #026 was found in resident #001's room. Resident #026 was redirected by staff from resident #001's room. Resident #026 stated to staff that he/she would kill them (no indication of who resident #026 was referring to). Resident #001 complained that resident #026 was pulling his/her legs and pushing his/her face into the mattress. Another resident #027, expressed concerns (to staff) that his/her foot and ankle had been twisted by resident #026, and that resident (#026) had hit him/her (resident #027) on the back of the head and neck, using his/her fist. Registered nursing staff assessed residents (#001 and #027), both residents complained of discomfort to their legs, resident #027 had redness on the neck.

Resident #001 complained of discomfort to his/her legs following the alleged physical abuse incident, which occurred.

Registered Nurse #111, who was the RN-Supervisor on duty during the alleged abuse incident, documented (in a progress note), that he/she was aware that resident #001 voiced concerns related to the alleged abuse by resident #026; and was aware that resident #001 was complaining of discomfort to his/her legs, post incident.

The CIR indicated the alleged abuse incident occurred at 0600 hours on a specific date, but the Risk Management Incident (located in Point Click Care, home's electronic documentation) identifies that that the time of abuse incident occurred at 0230 hours. The Director of Care indicated (to the inspector) that based on interviews with Registered Nurse #111 and personal support workers who had worked that night, the time of the

alleged abuse had occurred at 0230 hours, as documented on the Risk Management Incident.

The substitute decision maker, for resident #001, was not notified of the alleged abuse, which resulted in injury and distress to the resident, until 1123 hours, approximately nine hours after the incident.

2. Related to Intake #001370-17, for Resident #027:

Resident #027 has a specific medical diagnosis and Resident #027 has a designated substitute decision maker (SDM) for all decisions, including care.

The Director of Care submitted a Critical Incident Report (CIR) on a specific date at 1116 hours, for an alleged incident of resident to resident physical abuse which occurred on the day prior at approximately 0600 hours. The following are details of the alleged incident:

Registered Nurse #111, who was the RN-Supervisor on duty during the alleged abuse incident, documented (in a progress note, on a specific date at 0610 hours), that he/she was aware that resident #027 voiced concerns related to the alleged abuse by resident #026; and was aware that resident #027was complaining of discomfort to his/her leg and ankle. RN #111 further indicated that resident #026 had hit resident #027 with his/her closed fist, to the back of his/her head and expressed concerns of resident #026 choking resident #027. RN #111 indicated in the documentation that resident #027 had red marks on his/her neck.

The Critical Incident Report indicated the alleged abuse incident occurred at 0600 hours on a specific date, but the Risk Management Incident (located in Point Click Care, home's electronic documentation) identifies that that the time of alleged abuse incident occurred on at 0230 hours (same date). The Director of Care indicated (to the inspector) that based on interviews with Registered Nurse #111 and personal support workers who had worked that night, the time of the alleged abuse had occurred at 0230 hours, as documented on the Risk Management Incident.

As per progress notes, on a specific date, the physician for resident #027 was notified of the injuries of resident at 0300 hours (same date).

The substitute decision maker, for resident #027, was not notified of the alleged abuse,

which resulted in injury and distress to the resident, until 0622 hours (approximately four hours later). Substitute Decision Maker voiced concerns as to the abuse of resident #027 and not being promptly notified of the incident. [s. 97. (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 resident's substitute decision maker (SDM) and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse/neglect of a resident that, resulted in physical injury of pain to the resident or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force were immediately notified of any alleged, suspected, or witnessed incident of abuse (or neglect) of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #001370-17, for residents #001, 026 and 027:

The Director of Care submitted a Critical Incident Report on a specific date at 1116 hours, for an alleged incident of resident to resident physical abuse which occurred the day before, during the early morning hours. The following are details of the alleged incident:

- Registered Nurse (RN) #111, who was the RN Supervisor on duty, indicated in the progress note, on a specific date at 0606 hours, staff reported to RN#111 that resident #026 was found in resident #001's room. Resident #026 was redirected by staff from resident #001's room. Resident #026 stated to staff that he/she would kill them (no indication of who resident #026 was referring to). Resident #001 complained that resident #026 was pulling his/her legs and pushing his/her face into the mattress. Another resident #027, expressed concerns (to staff) that his/her foot and ankle had been twisted by resident #026, and that resident (#026) had hit resident #027 on the back of the head and neck, using his/her fist. Registered nursing staff assessed residents (#001 and #027), both residents complained of discomfort to their legs, resident #027 had redness on his/her neck. The incident was said to have occurred at approximately 0230 hours on a specific date.

Program Support Services Manager (PSSM), who was the Manager on Call on the date of the incident, indicated (to the inspector, on March 01, 2017) that RN #111 did not notify police of the alleged physical abuse of resident #001 and #027, by resident #026. PSSM indicated RN #101 notified the police of the alleged abuse and injuries to residents involved on a specified date, following notification to her (PSSM, after 1100 hours).

Registered Nurse #111 was not available for interview during this inspection. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected of witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Related to Intake #003500-17, for resident #029:

Family (#032) indicated (to the inspector, on February 28, 2017) that resident #029's washroom is frequently observed to have brown splatter on the walls, beside and behind the toilet, on the toilet tank and on the seating surface of the raised toilet seat. Family #032 indicated that the washroom is shared between resident #029 and a co-resident. Family indicated resident #029 is dependent on staff for all aspects of toileting. Family #032 believes that the brown splatter is fecal matter.

The washroom was observed (by the inspector) on February 28, and March 01, 2017,

the following was observed:
- On February 28, (at approximately 1300 hours) and on March 01, 2017 (at 0900 hours (hrs), 1000 hrs, 1100 hrs, 1200 hrs, 1300 hrs and 1400 hrs), brownish splatter was visible on the wall adjacent to the toilet, on the wall behind the toilet, and on the toilet tank and lid. A piece of dried tissue (measuring approximately five centimeters) with brown staining was adhered to the side of the toilet tank (during all observations on March 01, 2017).
- Cobwebs were observed under counter-top vanity and underside of the cupboard (identified as being in use for bed B), in the identified washroom.

Housekeeping Aid (HSK) #134 indicated (to the inspector) on March 01, 2017 at approximately 1100 hours that the washroom had been cleaned earlier that morning. Housekeeping Aide #134, who is the full-time housekeeper for this resident home area, indicated she had cleaned the toilet, sink and counter-tops in the identified washroom. HSK #134 indicated no awareness of cleanliness issues relating to this washroom. HSK #134 indicated that walls in the washroom are cleaned weekly and/or more often if cleanliness issues are identified.

The Executive Director observed washroom (with the inspector) on March 01, 2017 at approximately 1400 hours, the same observations as mentioned above were observed. Executive Director indicated it is her belief that the co-resident who shares the washroom with resident #029, toilets themselves and has been identified to have bowel care issues (explosive loose bowel movements).

Environmental Services Manager indicated being newly hired in mid-January 2017 and, was not aware of the cleanliness issues occurring in the identified washroom (#2214). Environmental Services Manager indicated the housekeeping staff should have identified the problems (brown splatter on walls and toilet itself), and taken action to ensure the washroom was frequently cleaned. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints that have been received concerning the care of a resident or the operations of the home to the Director.

The Director of Care indicated (to the inspector, on March 01, 2017) that she had received written correspondence from the Substitute Decision Maker (SDM) #031, for resident #028, on a specific date and time. The written correspondence by SDM provides the following details:

- Resident #028 called me at 0400 hours in a hell of a state, saying he/she wanted to go to the bathroom. Resident stated was told (by staff) he/she couldn't and that they should go in their brief. Resident #028 was mortified that he/she was told to go in the brief; stated he/she still has self-respect and refused.
- Substitute Decision Maker indicated receiving a second call from resident that night, stating he/she had been left to sit on a bed pan for over fifteen minutes. SDM indicated resident has a specific medical condition and sitting like that (on a bedpan) for that long is extremely painful and not good. Substitute Decision Maker indicated that the Personal Support Worker (PSW) directly involved was PSW #118.
- Substitute Decision Maker inquired (in the correspondence to DOC) as to the policy for toileting residents during the night. SDM asked if residents are not allowed to use toilet at night.

The Director of Care indicated that the written correspondence from SDM #031 was not forwarded to the Director, but she did submit a Critical Incident Report which spoke to the alleged abuse incident. The Director of Care indicated that she was in agreement, the CIR submitted did not reference the written correspondence from SDM. [s. 22. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the admission care plan included, at minimum, any risks the resident may pose to others, including any potential behavioural triggers and safety measures to mitigate those risks.

Resident was admitted to the long-term care home, specified unit, on a specific date. Resident #026 has a specific medical diagnosis. Resident is independent for mobility and requires no mobility aides.

The following progress notes are documented by registered nursing staff on resident's day of admission:

- On the date of admission- resident #029 had a history of exhibiting responsive behaviours, specifically physical aggression towards others, the most recent episode of physical aggression occurred approximately two weeks prior to admission, and occurred at another long-term care home where resident #029 resided.
- On the date of admission - Substitute Decision Maker (SDM) indicated (to the RAI-Coordinator) that resident exhibits responsive behaviours and may not be complaint with care, especially in the morning. SDM communicated that resident can become physically aggressive if suddenly awoken from sleep and further indicated that staff should exercise caution when approaching resident for care.

Progress Notes (for resident #026) reviewed (by the inspector) for a period of the first four days in the home, contained documentation detailing incidences in which resident #026 exhibited responsive behaviours (restless, pacing halls and entering co-residents rooms, lying in co-residents bed, refusing medications, threatening others (showing his/her fist), hitting out and grabbing resident #034 during this review period.

The Resident Move-In Assessment/Plan of Care (initiated on the day of admission) was provided (to the inspector) by the Director of Care and the Associate Director of Care; both indicated that this was considered the admission care plan. The Resident Move-In Assessment/Plan of Care was reviewed (by the inspector) and failed to provide documentation of the risk that resident #026 posed or may pose to others, specific to exhibited responsive behaviours, including any potential behavioural triggers and safety measures to mitigate the risk. [s. 24. (2) 2.]

WN #12: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Related to Intake #003500-17, for resident #029:

Resident #029 has a medical diagnosis which includes cognitive impairment. Resident #029 is dependent on staff for all activities of daily living. Resident #029 is wheelchair bound, foot propels and wanders aimlessly about the resident care areas, located on the second floor of the long-term care home.

Family #032, who is the primary care contact, for resident #029 (is not the substitute decision maker) indicated (to the inspector, on February 28, 2017) that Family#032 requested, on more than one occasion, for staff to place resident #029 into bed following lunch to allow resident to nap. Family #032 indicated resident is not able to consistently request a nap due to cognitive impairment. Family #032 indicated that he/she visits three to four times weekly and often finds resident exhausted when he/she arrives for visits. Family #032 believes that staff are not following their (family) requests. Family #032 cannot recall dates of the requests or who he/she asked.

Resident #029 indicated (to the inspector, on March 02, 2017, at approximately 1330 hours) that he/she was tired and wanted to have a nap. When asked if he/she had told staff that he/she wanted to have a nap, resident replied, they won't let me lie down. Resident was tearful during this interaction with the inspector.

Personal Support Worker (PSW) #130, who was working on the resident home area where resident #029 resides, indicated (to the inspector, on March 02, 2017) that she wasn't sure if resident #029 has a nap in the afternoon.

Registered Practical Nurse #102 indicated (to the inspector, on March 02, 2017) that resident #029 doesn't routinely lay down for naps. RPN #102 indicated being aware that Family #032 has requested for resident to be put into bed for naps in afternoon, but indicated that resident #029 will often refuse to nap and is left up in the wheelchair.

The plan of care was reviewed (last revision date of January 13, 2017) by the inspector. The plan of care did not include resident #029's sleep pattern and or preferences. [s. 26. (3) 21.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Related to Intake #003500-17, for resident #029:

Resident #029 has a specific medical diagnosis. Resident has been assessed by Registered Dietician to be at high nutritional risk due to poor food and fluid intake and choking history.

The plan of care, for Resident #029, (last revision dated of October 18, 2016) indicated requires set up, supervision and encouragement for all meals due to risk of choking.

Resident #029 was observed in the dining room (by the inspector) on March 01, 2017, between 0850 hours to 0945 hours. Resident #029 was served the cold cereal at approximately 0900 hours. At approximately 0909 hours, a personal support worker placed a plate containing two slice of toast (no crust) with jam, scrambled eggs and two orange segments; the plate was placed on the table to the right of the resident. Resident #029 was still eating the cereal. Resident #029 did not request the toast with jam, scrambled eggs or oranges. The plate containing the toast with jam, scrambled eggs and oranges sat on the table, untouched by resident #029 for approximately twenty-nine minutes, before a staff arrived at the table and then placed the food plate in front of resident #029 and handed resident a piece of toast with jam. Resident #029 was still eating the cereal, when staff handed him/her the toast with jam.

Registered Dietician (RD) indicated (to the inspector, on March 29, 2017) that resident #029 is to be served one course at a time. RD indicated personal support workers need to be monitoring resident's intake due to resident's choking risk and to ensure he/she is consuming the meals and fluids. RD indicated the plate of toast, eggs and oranges should not have been placed on the residents table until resident had finished the cereal. [s. 73. (1) 8.]

Issued on this 7th day of April, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH GILLIS (623), KELLY BURNS (554), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_591623_0002
Log No. / Registre no:	003072-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 6, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAY RIDGES 900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To REVERA LONG TERM CARE INC., 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies developed to respond to responsive behaviours exhibited by resident #026 and or any other resident.

The licensee will further ensure that actions are taken to respond to the needs of resident #026 or any other resident, including assessments, reassessments, interventions and that the resident's responses to the intervention(s) are documented.

The home's plan must include:
- How and when the home will seek appropriate and timely support if implemented strategies provided prove to be ineffective;
- Processes for monitoring that planned interventions for responding to responsive behaviours are implemented by staff and the effect of the intervention is documented;
- A process for reassessment, monitoring and re-evaluation of non-pharmacological and pharmacological strategies.

This plan must be submitted in writing to MOHLTC, Attention: Kelly Burns, Long-Term Care Homes Inspector (Nursing), and faxed to, (613) 569-9670 on or before April 24, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours, including, reassessment, and alternative interventions.

Related to Intake #001370-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on a specified date, specific to an alleged incident of resident to resident physical abuse, which occurred on a different specified date.

Resident #026 has a specified medical diagnosis. The resident was admitted, to a specified unit of the long-term care home, on a specified date, and was ambulatory on admission, and was able to wander about the resident home area.

Registered Practical Nurse (RPN) #105 , Personal Support Worker (PSW) #116, and the Director of Care indicated (to the inspector) that resident has a known history of exhibiting responsive behaviours, specifically verbal and physical aggression towards co-residents and staff.

The written plan of care (in place at the time of this inspection), related to responsive behaviours exhibited by resident #026, and associated interventions was reviewed.

Registered Practical Nurse #105 and PSW #116 indicated specific identified triggers to resident #026's responsive behaviours. Both indicated resident #026 was unpredictable, and mood was labile.

Progress notes encompassing a specified period were reviewed (by the inspector), documentation reviewed provided detailed incidences of exhibited behaviours. Resident #026 was eventually transferred to hospital for assessment on a specified date.

On a specified date, the hospital contacted the long-term care home, indicating resident had received a specific medication and was being returned back to the long-term care home.

Registered Practical Nurse, who is on the BSO Team (Behaviour Support) reviewed resident's clinical health record, upon return to the long-term care home and faxed information received to Ontario Shores for future assessments and possible acceptance to Geriatric and Neuropsychiatry Outpatient Services (GNOS).

The following Plan was implemented on a specified date following resident's return from the hospital:
- 24 hour 1:1 staffing and external security guard.
- Relocate to Private (Guest) Suite off of unit for safety of others;
- Meals to be provided in games room, supervised by 1:1 staff. Use of plastic utensils only;
- Specific medication three times daily to commence. Verbal consent, for chemical restraint, received by substitute decision maker. (Note: Signed Consent on file, time of this inspection)

Registered Nurse(s) #110 and #111 were unavailable for interviews during this

inspection.

Detailed documentation, by registered nursing staff confirm that on twenty-two (approximate) separate dates resident #026 exhibited verbal and/or physical aggression, and threatened to kill both co-residents and staff. The documentation provides support that resident #026's behaviours escalated and on several dates became volatile, affecting the quality of life for other resident's residing on resident home area. Registered Nursing Staff have documented that interventions, both non-pharmacological and pharmacological, were minimally effective or ineffective. The review of the above documentation failed to support that when interventions were described to be ineffective, that alternative assessments, and or measures/interventions were taken to mitigate risk to co-residents and or others.

At the time of this inspection, resident #026 had been returned to a private room, on a specific unit. Resident continues to have 1:1 staffing in place on all shifts, with the additional support of an external security guard in place. Resident is no longer ambulatory, is in a wheelchair and is medicated, as per recommendation by Ontario Shores. Resident is currently awaiting further assessment and possible admission to Ontario Shores. [s. 53. (4) (c)] (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Gillis

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