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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2017	2017_650565_0010	011001-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

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

MATTHEW CHIU (565), JOVAIRIA AWAN (648), JOY IERACI (665), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, and 20, 2017.

During the course of the inspection, the following Critical Incident System (CIS) Intakes were inspected:
- 002867-17, 003531-17, 003877-17: related to staff or visitor to resident abuse

- 024663-16, 033235-16, 002639-17, 003654-17, 007425-17: related to resident to resident abuse
- 024866-16: related to resident injury with unknown cause
- 028312-16, 033603-16, 007942-17, 001807-17: related to resident fall with injury
During the course of the inspection, the following Complaint Intakes were inspected:
- 029795-16, 011769-17: related to resident to resident abuse
- 031877-16, 002531-17, 003707-17, 009133-17: related to improper care of resident
- 004431-17: related to responsive behaviours
- 012614-17: related to staff to resident neglect
During the course of the inspection, the following Follow up to Order Intake was inspected:
- 004236-17: related to Compliance Order #001, #002, #003, and #004

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Director of Dietary Services (DDS), Director of Environmental Services (DES), Registered Dietitian (RD), Nurse Manager (NM), Behaviour Support Resource Team (BSRT) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Payroll and Human Resources Generalist (PHRG), Physiotherapist (PT), Physiotherapy Assistant (PTA), Restorative Care Aide (RCA), Housekeeping aides (HAs), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council, menus, staff training records, staffing schedules and relevant policies and 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
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **9 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. 19.	CO #002	2016_268604_0015	565
O.Reg 79/10 s. 53. (4)	CO #003	2016_268604_0015	565
O.Reg 79/10 s. 55.	CO #004	2016_268604_0015	565
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_268604_0015	565

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

Findings/Faits saillants :

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

a. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) Director, related to abuse. The CIS report stated that on an identified date, resident #007 demonstrated identified responsive behaviours towards an identified Personal Support Worker (PSW) who performing a specified PSW care. The identified PSW attempted an identified intervention which made resident #007 increasingly agitated and the PSW required assistance from the nurse. As the PSW stepped away, resident #007 had an identified interaction towards resident #008 who was walking towards him/her to get to his/her room, causing resident #008 to fall and sustained an identified injury.

Record review for resident #007 indicated he/she was admitted to the home on an identified date and was transferred to hospital on another identified date.

A review of resident #007's written plan of care revealed an identified responsive behaviour focus. Further record review indicated specified direction was given to PSW for the specified PSW care when on duty with resident #007.

Inspector #604 attempted to interview resident #008 and the resident indicated he/she is unable to recall any information related to the incident above and he/she was doing well.

An interview with PSW #114 confirmed he/she worked on the day of the above mentioned incident and stated he/she is aware of resident #007 who has responsive behaviours. The PSW stated resident #007 can have no behaviours on one day but demonstrating identified responsive behaviours on the other day by demonstrating identified interactions. The PSW added that resident #007 had a specified PSW care a few weeks after his/her admission to the home as he/she began to show signs of the identified responsive behaviours. The home utilized the specified PSW care on all shifts to addressing the resident's responsive behaviours. The PSW stated when the resident demonstrates the identified responsive behaviours, certain identified strategy would be

used by the PSW who performing the specified PSW care to the resident.

An interview with Registered Practical Nurse (RPN) #126 confirmed he/she worked on the day of the above mentioned incident and recalls the incident which occurred between resident #007 and #008 as indicated above. The RPN stated resident #007 had unpredictable identified responsive behaviours towards staff and other residents in the home and had the specified PSW care on all three shifts. The RPN stated when resident #007 demonstrated the identified interaction towards resident #008, it caused the resident to fall down to the floor and sustaining an identified injury. The RPN stated the PSW, who was performing the specified PSW care for resident #007, was attempting an identified intervention which triggered the resident's increased identified responsive behaviours.

An interview conducted with PSW #128 confirmed he/she worked on the day of the above mentioned incident and was the PSW performing the specified PSW care for resident #007 for that shift. The PSW indicated the resident had the identified responsive behaviours. The PSW stated he/she recalls the incident as indicated above and when resident #007 demonstrated the identified responsive behaviours towards resident #008, it caused resident #008 to fall down to the floor and sustained the identified injury. The PSW indicated that the home had the specified PSW care for resident #007 but the PSW was unable to redirect the resident when he/she demonstrated the identified responsive behaviours, and the PSW stated the strategies were not effective most time.

b. A second incident involving resident #007 was reported to the MOHLTC Director related to abuse through a CIS report. The CIS report indicated that on an identified date, resident #007 demonstrated an identified responsive behaviours in the room of resident #009 and #010 who shared the same room. Resident #009, #010 and an identified PSW, who was performing a specified PSW care to resident #007, intervened with identified interventions. Subsequently, resident #007 demonstrated an identified action causing resident #009 to fall and sustained identified injuries, and resident #010 was hit but no injuries were identified at the time of the incident. The PSW was able to redirect resident #007 down the hall but resident #007 continued demonstrating identified responsive behaviours towards the PSW.

A review of resident #007's written plan of care indicated an identified responsive behaviours focus. The focuses and interventions are identified as above mentioned.

An interview with resident #010 confirmed the above incident occurred and stated he/she

did not have any injuries. The resident stated that the identified PSW who was with resident #007 could not handle the resident when he/she would demonstrate the identified responsive behaviours.

An interview with resident #009 confirmed the above incident occurred and stated that resident #010 was in the room as they shared the room. The resident stated he/she saw resident #007 coming and resident #010 attempted an identified action. Subsequently, resident #007 demonstrated identified responsive behaviours and actions towards resident #009 and #010. As a result, resident #009 fell and had pain. The resident indicated resident #007 had been demonstrating identified responsive behaviours and the resident has a specified PSW care all the time but the PSW performing the specified PSW care can't handle the resident's identified responsive behaviours.

Inspector #604 was unable to interview PSW #161 who was witness to the incident as indicated above.

An interview with RPN #127 confirmed he/she worked on the day of the above mentioned incident. The RPN stated resident #007 would demonstrate the identified responsive behaviours, and monitoring the resident was the only the strategy in place for the PSW, who performs the specified PSW care to the resident, when he/she demonstrated the behaviours. The RPN stated he/she is aware of the above incident and acknowledged that resident #009 sustained an identified injury when he/she fell, and resident #010 sustained no visible injuries.

An interview with Registered Nurse (RN) #158 confirmed the above mentioned incident had happened. The RN stated that the PSW, who performed the specified PSW care to resident #007, was unable to control or redirect resident #007. The RN stated resident #007 presented with the identified responsive behaviours. The RN stated resident #009 sustained the identified injury and resident #010 had no visible injuries. Both residents were distraught and visually upset.

An interview with the home's Behavioural Support Resource Team (BSRT) Lead #144 indicated shortly after resident #007 was admitted, the resident was noticed to present the identified responsive behaviours. The BSRT Lead indicated when resident #007 demonstrated identified responsive behaviours, the PSW performing the specified PSW care would intervene with identified interventions. The BSRT Lead indicated he/she was aware of the two incidents mentioned above, where resident #008 and #009 sustained identified injuries.

An interview with the Director of Care (DOC) indicated he/she is was aware of the above two incidents that involving resident #007. The DOC stated the home had the specified PSW care with resident #007 as his/her presented with unpredictable responsive behaviours and the home had placed the specified PSW care to ensure resident #007 and other residents in the home were safe. The DOC stated the home had identified specialized in-home and outside resources involved to assess resident #007's responsive behaviours. The DOC stated resident #007's actions caused resident #008 and #009 sustained identified injuries.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual. During the course of the inspection the inspectors inspected six CIS reports related to responsive behaviours in the home. A review of resident #007's written plan of care did not show evidence of the home developing effective procedures and interventions to address resident #007's identified responsive behaviours and also for the identified trigger. The written plan of care indicated triggers but did not have interventions put in place to minimize the risk of altercations and potentially harmful interactions between and amongst residents. Resident #007 demonstrated identified responsive behaviours towards resident #008 and #009 causing them to sustain the identified injuries as above mentioned.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that there have been previous non-compliances related to the Long-Term Care Homes Act O.Reg. s.55, which is as follows:

1) 2016_268604_0015, Resident Quality Inspection in June 20, 2016 – CO was issued. [s. 55. (a)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right, to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

The home submitted a CIS report related to staff to resident abuse. As per the CIS report, resident #051 reported to the DOC that he/she heard PSW #164 tell resident #052 an identified verbal communication and then told resident #051 to go back to his/her room.

Record review revealed that on an identified date and time, resident #052 had an identified responsive behaviour, and was found on his/her bedroom floor. PSW #164

called for assistance, and PSW #155 came to assist resident #051. The progress notes further indicated resident #051 was awoken by the noise that was made by resident #052.

Interview with resident #051 revealed on the identified date, he/she was outside his/her bedroom door and saw two PSWs with resident #052 who was lying on the floor. Resident #051 indicated when PSW #164 saw him/her, PSW #164 told him/her in an identified verbal communication. Resident #051 stated PSW #164 spoke to him/her in a mean tone and was rude. The resident stated that this incident made him/her feel worried and scared of how rudely the staff will treat him/her in future.

Interview with PSW #164 revealed that on the identified date when he/she left resident #052's room and walking back to another resident's room directly across, the PSW saw resident #051 was outside his/her room in the hallway. The PSW stated resident #051 appeared to be upset, and he/she told the resident it is ok and go back to sleep. The PSW indicated that when he/she spoke to resident #051, his/her voice would have been louder than usual because of resident #052's identified responsive behaviours. The PSW indicated he/she could have walked up to resident #051 to tell him/her it was ok instead of speaking to the resident from across the hallway. PSW #164 acknowledged he/she could have been more compassionate when he/she communicated with resident #051 and should have treated the resident in a respectful manner according to the Resident's Bill of Rights.

Interview with the DOC indicated the home's investigation revealed resident #051 was really upset about the incident. The DOC further indicated that he/she informed PSW #164 that he/she should have walked to resident #051 to tell him/her to go back to his/her room, be courteous, and approach the resident in a respectful manner. The DOC acknowledged resident #051 was not being treated in a respectful and courteous manner by PSW #164 according to the Resident's Bill of Rights. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right, to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, was fully respected and promoted.

On June 22, 2017, at 0900 hrs, the inspector observed a medication cart was unattended, unlocked and located across from the nursing station. The EMAR tablet attached to the medication cart was observed showing the morning medications for resident #055. It was observed that RPN #109 was in the dining room assisting staff with

the breakfast meal service. RPN #109 returned to the medication cart and acknowledged that he/she left the medication cart and EMAR tablet screen unlocked when he/she went into the dining room.

Interview with RPN #109 indicated when the EMAR tablet screen was unattended, it should be locked to ensure that the residents' personal health information (PHI) is kept private. The RPN acknowledged that on the above mentioned date and time, resident #055's morning medications was visible on the EMAR tablet screen and the resident's PHI was not kept confidential.

Interview with the DOC indicated that it is the home's expectation for the EMAR tablet screen be locked when unattended by a registered staff to ensure that the PHI of residents are kept confidential and private. The DOC further indicated it is the home's expectation that the medication cart be locked when unattended as residents medications packages include PHI that needs to be kept confidential. The DOC confirmed that resident #055's PHI was not kept confidential as required. [s. 3. (1) 11. iv.]

Additional Required Actions:

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

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Review of a CIS report revealed that on an identified date, resident #039 fell and he/she was sent to hospital. As a result, the resident sustained an identified injury and returned to the home on another identified date after an identified medical treatment.

Review of an identified resident's plan of care revealed the resident had both cognitive and physical impairments and was at risk for fall. The plan of care further stated the resident requires a specified staff assistance for transfer.

Interview with resident #039's family member indicated after the resident returned to the home, his/her mobility function had changed. The family stated that staff members are using a specified assistance for transfer, and it was not the same as what being mentioned above in the plan of care.

Interview with PSW #128 indicated after the above mentioned fall, the resident has been transferred by staff using the specified assistance as the one mentioned by the family member. Interviews with PSW #136 and RPN #138 indicated when the resident returned to the home after the hospital stay, staff members transferred the resident using the

specified assistance as being mentioned above in the plan of care. Since the resident had an identified condition, the resident was assessed by Physiotherapist (PT) #139 and later determined to use the specified transfer assistance as the one mentioned by the family member. The staff members indicated the plan of care for the resident's transfer assistance was not based on the PT's assessment and the needs of the resident.

Review of progress notes and interview with PT #139 indicated on an identified date, he/she completed a transfer assessment for resident #039 and recommended the use of the specified transfer assistance as the one mentioned by the family member. PT #139 recorded the recommendation on the progress notes and verbally communicated it to nursing staff.

Interview with the DOC confirmed that resident #039's assessed transfer care needs had changed after the physiotherapy transfer assessment, and the transferring plan of care was not based on the transfer assessment and the needs of the resident. [s. 6. (2)]

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

During stage one of the Resident Quality Inspection (RQI), resident observation revealed resident #002 has potential restraints.

Resident #002 uses an identified mobility aid as a personal assistance services device (PASD) to assist with mobility. Review of the identified plan of care indicated staff to transfer the resident from the identified mobility aid to a chair during meal times and to transfer the resident back to the identified mobility aid as tolerated after meals.

On June 22, 2017, resident #002 was observed to be having his/her lunch in the dining room sitting on his/her identified mobility aid.

Interviews with PSW #111, #122, #133, #143, and RPN #109 indicated resident #002 should be sitting on a dining chair, but not the identified mobility aid, for his/her meal. The staff members further indicated that resident #002 was sitting on a dining room chair when he/she was having lunch on the above mentioned date. However, the staff members informed the inspector that they did not assist their colleagues in transferring the resident out of the identified mobility aid onto the dining room chair for the lunch meal service.

Review of video footage of the lunch meal service revealed resident #002 was sitting on his/her identified mobility aid instead of the dining room chair as per plan of care.

Interview with Associated Director of Care (ADOC) #106 indicated that it is the home's expectation for the plan of care to be followed by staff. The ADOC stated that the plan of care was not followed for resident #002, as resident was not sitting on the dining room chair during his/her lunch meal.

Interview with the DOC indicated it is the home's expectation for the plan of care to be followed. After review of the above mentioned video footage, the DOC confirmed the home failed to ensure that the care set out in the plan of care is provided to the resident #002 as specified in the plan. [s. 6. (7)]

3. The home submitted a CIS report to the MOHLTC Director related to resident to resident altercation with injury. As per the CIS report, on an identified date, resident #053 demonstrated an identified action towards resident #054 in an identified home area. Resident #054 then responded towards resident #053 with an identified action. As a result, resident #053 sustained an identified injury.

Record review revealed resident #053 has identified responsive behaviours with co-residents including resident #054. Identified Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments indicated resident #053 had identified moods and responsive behaviours.

Interviews with RPN #178 and the BSRT Lead #144 revealed resident #053 demonstrated the identified responsive behaviours towards resident #054 when resident #054 was sitting quietly in the identified home area.

Review of the progress notes dated indicated on the identified date, resident #053 was a risk of harm to co-residents and staff as he/she demonstrates identified responsive behaviours. A behaviour tracking was to be completed every shift for seven days after assessment by the BSRT Lead #144 on an identified date.

Review of the behavioural tracking documentation with the BSRT Lead revealed three identified dates were not completed as per plan of care.

Interview with RPN #178 indicated it is the home's expectation to complete the behavioural tracking for every shift. The RPN stated it is the registered staff's

responsibility to ensure that the behavioural tracking is completed during their shift. The RPN indicated completion of the behavioural tracking is important so that the BSRT Lead can analyze resident #053's behaviours so that staff are better able to manage the resident's responsive behaviours and implement new interventions. RPN #178 acknowledged that the plan of care regarding completing the behavioural tracking for resident #053 was not provided as specified in the plan.

Interview with BSRT Lead #144 indicated the difficulty in determining resident #053's behaviour patterns and triggers. According to the BSRT Lead, resident #053 had identified risk for demonstrating responsive behaviours towards staff and co-residents. The BSRT Lead noted in his/her progress note on an identified date that resident #053 was a risk of harm to co-residents and staff because of his/her identified responsive behaviours. As per BSRT Lead, completion of the behavioural tracking form will assist the home in decreasing the resident's behaviour, find new interventions and reduce harm to other residents and to resident #053. The BSRT Lead further indicated that it is difficult for the home to accurately analyze resident #053's behaviours when the behavioural tracking form is not fully completed as per home's expectation. The BSRT Lead acknowledged the planned care was not provided as specified in the plan since the behavioural tracking was not completed for resident #053. [s. 6. (7)]

4. Review of a CIS report revealed resident #038 fell on an identified date. The resident was sent to hospital and diagnosed with an identified significant injury.

Review of resident #038's plan of care and progress notes revealed the resident had both cognitive and physical impairments and was at risk for fall. The identified falls prevention plan of care revealed an identified intervention should be applied to the resident when he/she is in bed.

Review of the resident's post fall assessment progress notes revealed on three identified dates, the resident fell during the night, and sustained identified injuries. The falls prevention interventions that were being implemented on those nights did not include the identified intervention.

Interviews with PSW #132 and RN #145 indicated the resident was at risk for falls due to identified medical conditions. The resident was unsteady and required using an identified mobility aid for ambulation but he/she forgot using it. The staff members indicated the resident should have been using the identified intervention as one of the falls prevention interventions for a long time before the above mentioned three falls at nights. RN #145

further indicated he/she was not aware if the use of the identified intervention was implemented for the resident until after these falls, and confirmed that the identified intervention was not applied for the resident when the above mentioned falls happened.

Interview with the DOC indicated staff members should follow the fall prevention plan of care for applying the identified intervention for resident #038 when he/she is in bed. The DOC confirmed since it was not applied for the resident during the above mentioned falls, the care set out in the fall prevention plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

A complaint was reported to the MOHLTC identifying a concern related to the provision of a specified area of care for resident #032.

Review of resident #032's identified written plan of care indicated the resident required assistance to use an identified furnishing for the specified area of care due to identified medical conditions. The written plan of care stated that resident #032 required an identified number of staff to provide the assistance to use the identified furnishing.

Interview with PSW #102 identified resident #032 only receives the specified area of care in bed instead of using the identified furnishing. PSW #102 stated that resident #032's care needs for the specified area of care had changed and he/she had not been provided physical assistance to use the identified furnishing in the past year. PSW #102 confirmed the plan of care did not identify the current manner in which resident #032 receives the specified area of care.

Interview with RPN #103 indicated the written plan of care for resident #032 was not reflective of his/her current needs as the resident required the specified area of care to be provided in bed.

Interviews with ADOC #115 and the Executive Director (ED) confirmed the resident's care needs for the specified area of care had not been reassessed and the care plan revised when the resident's care needs had changed. [s. 6. (10) (b)]

6. 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, the care set out in the plan has not been effective.

Review of a CIS report revealed resident #038 fell on an identified date. The resident was sent to hospital and diagnosed with an identified significant injury.

Review of resident #038's plan of care and progress notes revealed the resident had both cognitive and physical impairments and was at risk for fall. On the identified date, a staff member found resident #038 lying on the floor in an identified home area. The resident was sent to hospital on the same day and subsequently diagnosed with the identified significant injury. The resident's history for falls revealed he/she had six identified falls within two months prior to the above mentioned fall incident.

Review of the resident's identified falls prevention plan of care revealed identified falls prevention interventions were put in place at the time of the above mentioned first fall.

Further review of the resident's post-fall assessments and fall prevention plan of care did not reveal any further interventions after the above mentioned six falls.

Interview with RN #145 indicated that the CIS reported fall for resident #038 had happened, and the resident was sent to hospital on the same day.

Further interviews with RN #145 and PSW #132 indicated the resident was at risk for falls due to identified medical conditions. The resident was unsteady and required to use an identified mobility aid for ambulation but he/she forgot using it. The staff members stated the plan had been ineffective to prevent the resident from falling and RN #145 confirmed that the resident had multiples falls during the above mentioned two months prior. The staff members confirmed the falls prevention plan of care had not been revised after these seven falls.

Interview with the DOC indicated the home's expectation is that the resident's plan of care should be reviewed and revised when the care set out in the plan has not been effective. The DOC confirmed that the falls prevention plan of care for resident #038 was ineffective and the falls prevention plan of care was not revised after the above mentioned six falls. [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 to ensure that:
- The care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
- The care set out in the plan of care is provided to the resident as specified in the plan,
- The plan of care is revised at any time when the resident's care needs change,
- The plan of care is revised at any other time when, the care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home has failed to ensure that that residents were protected from abuse by anyone in the home.

For the purpose of the Act and Regulation, "Physical Abuse" means the use of physical force by a resident that causes physical injury to another resident.

The home submitted a CIS report to the MOHLTC Director indicating on an identified date, resident #040 demonstrated identified responsive behaviours towards resident #042. RPN #103 intervened and separated the residents. As a result, resident #042 sustained an identified injury.

Review of progress notes and plans of care for both resident #040 and #042 revealed both residents had cognitive impairments. Resident #040 had history demonstrating identified responsive behaviours towards staff and residents. The progress notes recorded, on the identified date in an identified home area, the above mentioned incident between resident #040 and #042.

Further review of resident #042's progress notes and incident records indicated the resident sustained an identified injury as a result of the incident.

Review of assessment records and behavioural plan of care for resident #040 indicated the Behavioural Support Services Mobile Support Team and identified outside specialized resources had been involved with the resident's responsive behaviours assessments, and staff were directed to implement an identified behavioural plan of care for the resident.

Interviews with RPN #103 indicated he/she witnessed the above incident. Resident #042 was standing in the hallway in an identified home area. When resident #040 passed in front of resident #042, he/she demonstrated the identified responsive behaviours towards resident #042 without any identified reason. RPN #103 immediately ran out to separate the residents. As a result, resident #042 sustained the above mentioned injuries.

Interview with RPN #103 and ADOC #115 confirmed that they considered the above incident as physical abuse towards resident #042, and the ADOC confirmed the home had failed to protect the resident from abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting the resident.

The home submitted a CIS report on an identified date to the MOHLTC Director. The CIS report indicated a PSW completed his/her care on resident #012 and noted the resident had an identified medical condition. The RN completed an assessment for the resident and noted the identified medical condition. The identified medical condition was monitored during the week and on an identified date, it was noted that the condition was more pronounced and an identified examination procedure was ordered. Two days later, the result of the examination indicated the resident had sustained an identified significant injury.

A review of resident #012's plan of care revealed the resident required a specified mechanical lift for transfer by two staff members.

An interview with PSW #160 confirmed he/she worked on an identified date, and he/she provided care to resident #012. The PSW indicated that the resident was to be transferred using the specified mechanical lift with the assistance of another staff member. The PSW stated on the identified date, he/she transferred the resident on his/her own by carrying out a physical lift as there was no other PSW staff available at that time. The PSW further indicated when the resident was in bed, he/she observed the resident had the above mentioned identified medical condition and reported it to RN

#158 who came to assess the resident. The PSW in closing confirmed that he/she did not perform a safe transfer as he/she transferred the resident on his/her own manually and was given a letter of warning by the home after the home completed their investigation indicating that he/she did not follow the home's transfer policies and put resident #012 at risk.

An interview with RN #158 confirmed he/she worked on the identified date in resident #012's home area. The RN indicated he/she was aware of resident #012's transfer status and the resident was a two person transfer mechanical lift but the resident was also transferred with a two person using a specified manual technique. The RN stated on the identified date, PSW #160 took resident #012 from the lounge and into the residents room and informed him/her that the resident had the identified medical condition, the RN stated he/she assessed the resident and identified the condition and documented his/her assessment on Point Click Care (PCC) and for monitoring. The RN added that PSW #160 did not inform him/her of him/her doing a transfer for resident #012. The RN stated the identified medical condition was indicative of an acute injury. The RN indicated that resident #012 was diagnosed with the significant injury on the identified date.

In addition, interviews with PSW #149 and #159 indicated that on the identified date, in the morning both staff had provided a two person transfer using the specified manual technique to the resident from bed to wheelchair. Both staff confirmed that the resident should have been provided a transfer using the specified mechanical lift and did not do this.

An interview carried out with ADOC #157 confirmed he/she submitted the above CIS report. The ADOC stated during the home's investigation PSW #160 revealed that he/she transferred resident #012 on his/her own on the identified date, and the resident was a two person mechanical lift, and the PSW received a written letter of warning and was given education on the home's lift policies. The ADOC stated PSW #160 did not follow safe transfer practices putting resident #012 at risk. The ADOC stated that the home was unable to determine the cause of the identified injury. [s. 36.]

2. Observations conducted for resident #021 on July 18, 2017, outside of his/her room during the course of the inspection identified PSW #102 entered resident #021's room at an identified time. Inspector did not identify other staff entering the room. Resident #021's door remained closed for a period of approximately 20 minutes during which time PSW #102 remained in the resident room. PSW #102 emerged with resident #021 from the resident room after providing care and proceeded to porter resident #021 to an

identified home area. The inspector returned to resident #021's room and confirmed no additional staff were in the room or hallway at this time. The inspector did not identify a mechanical lift in the resident room or in the hallway of the home area.

Record review of resident #021's written plan of care identified he/she required transferring assistance related to cognitive deficit with two staff using a mechanical lift.

During this period, PSW #119, #120, and RN #118 were observed in an identified home area engaging with residents. RN #118 confirmed the fourth PSW on that shift was providing a shower in the tub during the observation period.

Interview with PSW #102 identified he/she was aware of resident #021's transfer directive as per the written plan of care. PSW #102 confirmed he/she had independently transferred resident #021 from the bed to the wheelchair. PSW #102 confirmed the transfer was not performed as per resident #021's assessed need.

Interview with RN #118 was conducted immediately following the above observation. Resident #021's written plan of care was reviewed with RN #118 and he/she confirmed the staff member did not follow the appropriate safe transferring technique as outlined for resident #021. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff uses safe transferring techniques when assisting the resident, to be implemented voluntarily.

WN #6: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

Review of a CIS report revealed RN #117 reported an alleged staff to resident abuse to the home's management on an identified date related to increased identified injuries of unknown cause that involved resident #032, #033, #034, #035, and #036.

Review of the plan of care for resident #033 revealed he/she had both cognitive and physical impairments. The progress notes dated on the identified date indicated the resident had an identified altered skin integrity and unexplained identified injuries in the recent weeks.

Interviews with RN #117, RPN #118, and ADOC #115 indicated the home uses a Skin and Wound Care Assessment tool to assess residents exhibiting altered skin integrity.

Review of the Skin and Wound Care Assessment records revealed no records for the above mentioned identified altered skin integrity and the identified injuries for the resident.

Interview with PSW #131 indicated he/she recalled resident #033 had the identified altered skin integrity and the identified injuries during the above mentioned period of time. The staff member was unable to recall when it was first reported and did not know what caused the identified altered skin integrity and the identified injuries.

Interview with RPN #118 indicated the resident had the identified altered skin integrity and the identified injuries first noted in the progress notes as above mentioned. The staff member confirmed the resident did not receive a skin assessment using the home's assessment tool.

Interview with ADOC #115 indicated the home's expectation for residents exhibited altered skin integrity including skin tear, they should receive skin assessments using the Skin and Wound Care Assessment tool. The ADOC confirmed that resident #033 had exhibited the above mentioned altered skin integrity and injuries and he/she did not receive the skin assessment as required. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #7: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person simultaneously assist more than two residents at the same time who need total assistance with eating or drinking.

During the course of the inspection, the inspector was approached by visitor #150 in an identified home area during a meal service. Visitor #150 indicated residents requiring feeding assistance from staff were not adequately assisted in the identified home area.

The following observations were made during the course of the inspection:
- On June 21, 2017, during lunch meal service, residents #022, #025, and #026 seated at an identified table in the identified home area appeared to require feeding assistance. All the three residents had been served meal items and PSW #120 was observed at the table to provide feeding assistance for these three residents.

Review of the written plans of care for residents #022, #025, and #026 indicated the residents required specified staff assistance for eating.

Staff interviews with PSW #102, #120, RPN #103, and ADOC #115 indicated staff were expected to provide assistance to no more than two residents at a time during meals. The staff members acknowledged this was not practiced in identified dining room due to the number of residents in the dining room requiring feeding assistance during the identified meal observation reviewed by the inspector.

Interviews with the ADOC #115 and the Director of Dietary Services (DDS) confirmed the legislative requirement that staff members assist only one or two residents at the same time who need total assistance with eating or drinking was not met. [s. 73. (2) (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 to ensure that no person simultaneously assist more than two residents at the same time who need total assistance with eating or drinking, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

While the inspector was conducting observations on July 10, 2017, in Heritage House, the tub room door was observed to be open at 1200 hrs. The tub room was unattended, and it had Arjohuntleigh disinfectant cleanser located under the sink. The inspector brought this to ADOC #106 and Nurse Manager (NM) #163's attention and they acknowledged that the tub room door was left open with no one in the room. The ADOC stated that a PSW just left the tub room with a resident.

The ADOC and NM indicated it is the home's expectation for the tub rooms to be closed and locked when not in use to ensure safety of the residents, and they further stated that there are items in the tub room that is a safety risk for residents. The ADOC and NM both confirmed that staff did not follow home's expectation to ensure that all hazardous substances in the tub room were kept inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in a medication cart that was secure and locked.

On June 22, 2017, at 0900 hrs, the inspector observed the medication cart to be unattended, unlocked and located across from the nursing station. It was observed that RPN #109 was in the dining room assisting residents with the breakfast meal service. RPN #109 returned to the medication cart and acknowledged that he/she left the medication cart unlocked when he/she went into the dining room.

The RPN indicated it is the home's policy to ensure that medications are secure and locked. The RPN stated that the medication cart has drugs of residents and must be locked when left unattended to ensure resident safety.

Interview with the DOC indicated it is the home's expectation for medication carts to be locked when unattended to ensure safety of the residents and the drugs stored in the cart. The DOC confirmed RPN #109 did not follow home's expectation ensuring drugs are stored in a medication cart that was secure and locked. [s. 129. (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 to ensure that drugs are stored in a medication cart that is secure and locked, 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 all staff participated in the implementation of the infection prevention and control program.

During the stage one of the RQI, the following observations were made by the inspector:
- First identified room: urine collector hat on the washroom floor.
- Second identified room: blue washbasin on the washroom floor.
- Third identified room: shared washroom with unlabelled washbasins placed in the washroom sink and stored on a hook under the sink, two unlabelled bedpans and white urine collection hat stored against the washroom towel bar, and an unlabelled green basket with identified personal items.
- Forth identified room: shared washroom with unlabelled identified personal items.

Interviews with PSW #112, #113, RPN #109 and #156 indicated it is the home’s expectation that personal items are to be labelled. PSW #112, #113 and RPN #156 further indicated washbasins are to be stored on hooks under the washroom sink. RPN #156 and PSW #112 stated urine collection hats are to be disposed of after use. The PSWs and RPNs acknowledged that the home’s IPAC practices were not followed.

Interview with ADOC #157, who is the IPAC Program Lead, indicated that the home has an IPAC program and staff receive IPAC education at least annually. ADOC #157 indicated the home's expectation related to the home's IPAC program:
- Washbasins are to be stored on the hooks under the washroom sink.
- Personal items are to be labelled in shared washrooms.
- Urine collection hats are one time use and be disposed of after use. If the staff are trying to get a specimen, the collection hat is to be stored on top of the toilet.
- Urinals, wash basins, and bedpans are to be labelled with resident’s name

The ADOC confirmed that the staff did not follow and implement the IPAC program in the above mentioned incidents. [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 to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: 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.

The inspector conducted a narcotic count audit on June 14, 2017, at 1045 hrs, on the Heritage House home area with RPN #101. During the narcotic count audit the inspector reviewed the narcotic book which consisted of the "Monitored Medication Record for 7-days card", for each individual resident and the RPN called out the names of the resident, the narcotic, and quantity on hand indicated on the narcotic card and the following discrepancies were found:
- Resident #003: The narcotic sheet indicated nine tablets on hand and the narcotic card showed eight tablets on hand.
- Resident #017: The narcotic sheet indicated 12 tables on hand and the narcotic card indicated ten tablets on hand.
- Resident #018: The narcotic count sheet indicated six tablets on hand and the narcotic card indicated five tablets on hand.

- Resident #019: The narcotic count sheet indicated nine tablets on hand and the narcotic card indicated eight tablets on hand.
- Resident #020: The narcotic count sheet indicated nine tablets on hand and the narcotic card indicated seven and a half tablets on hand.
- Resident #020: The narcotic count sheet indicated nine capsules on hand and the narcotic card indicated eight capsules on hand.

The home follows the Medical Pharmacies policy and procedures for medication administration. The "Combined Individual Monitored Medication Record with Shift Count", policy number 6-7, dated February 2017, under procedure number four directed staff to sign each time a dose is administered, including the date, time, amount given, amount wasted, and new quantity/balance remaining.

An interview with RPN #101 indicated it was the home's policy that narcotics be signed off once administered and confirmed he/she administered the above narcotics to the residents during the morning medication pass at 0800hrs, and had not yet signed off the "Monitored Medication Record For 7-days Cared" sheet.

An interview with the ADOC #106 stated it was the home's policy that registered staff sign off the "Monitored Medication Record For 7-days Cared" sheet once the narcotic has been administered and indicated the RPN did not sign off the above "Monitored Medication Record For 7-days Cared" sheet for the identified residents and the home's policy was not followed. [s. 8. (1) (b)]

WN #12: 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 license has failed to ensure that any written complaints that have been received concerning the care of a resident were immediately forwarded to the Director.

The MOHLTC received a complaint on an identified date identifying concerns raised by resident #072's Substitute Decision Maker (SDM) regarding the resident's care in a written email format.

Interview with the SDM identified he/she provided the written complaint to the home on the identified date. Record review did not did identify the home had submitted the written complaint to the Director.

Interview with the DOC identified that he/she was aware that all written complaints received by the home must be immediately forwarded to the MOHLTC as per ministry guidelines and as iterated in the homes complaints management program. Review of the homes submission of the complaint with the DOC confirmed it was submitted to the Central Intake Assessment and Triage Team (CIATT) general inbox nine days after, but not immediately. [s. 22. (1)]

WN #13: 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 home failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in risk of harm and unlawful conduct that resulted in risk of harm to a resident, immediately report the suspicion and the information upon which it was based to the director.

For the purpose of the Act and Regulation, "verbal abuse" means 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.

During the course of the inspection related to a CIS report related to resident #021, the inspector was made aware of a threat of physical abuse directed to resident #073 was made by an identified person.

Record review of resident #021's progress notes revealed the identified person had approached RN #117 on an identified date, and stated an identified threat of physical abuse towards resident #073. Progress note dated another identified date documented that the identified person approached registered staff stating another identified threat of physical abuse towards resident #073. Review of the progress notes identified the DOC was made aware of these two incidents and took identified actions.

During staff interviews related to resident #021, RN #117 reported the identified person had approached him/her on an identified date and stated the identified threat of physical abuse towards resident #073. RN #117 indicated the home took the identified action after this threat was made against resident #073. RN #117 confirmed he/she identified this as a verbal threat of abuse against a resident and reported the threat against resident #073 by the identified person to the DOC.

Interview with the DOC identified the home became aware that the identified person verbally threatened to injure resident #073 on an identified date. The DOC indicated the home took identified action towards the identified person. The DOC confirmed the home did not notify the Director of the verbal threat of abuse. [s. 24. (1)]

2. A complaint was submitted to the MOHLTC on an identified date by RPN#103 alleging staff to resident neglect of resident #022 and #032 by PSW #131.

Interview with RPN #103 identified he/she was made aware of the alleged neglect of resident #022 and #032 by PSW #131 during the morning shift report from outgoing PSW #130 on two identified dates respectively. RPN #103 indicated that he/she was made aware the allegation that PSW #131 neglected resident #022 and #032 by not providing a specified care when the residents needed. RPN #103 identified documentation, dated the same date that the complaint was submitted to the MOHLTC, of his/her communication of the allegation of neglect to ADOC #115.

Interview with the DOC and ED identified that as per the home's policy to promote zero tolerance of abuse and neglect of residents, staff in the home are expected to immediately report suspected abuse or neglect of a resident to the charge nurse and if the home's management is not available, it should be reported the Director.

Interview with ADOC #115 indicated he/she was initially notified on the same date that that the complaint was submitted to the MOHLTC of the alleged neglect of resident #022 and #032. ADOC #115 confirmed RPN #103 did not immediately notify the home's management of the suspected neglect of resident #022 and #032 as required by the home's policy. [s. 24. (1)]

WN #14: 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. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During the stage one of the RQI, the RAI-MDS most recent assessment revealed resident #005 was at low risk related to incontinence.

Record review of resident #005's RAI-MDS assessments revealed the resident's specified continence status and physical functioning had declined in an identified quarterly period, and the resident required a specified assistance for continence care.

Interview with RPN #109 indicated it is the home's expectation for a continence assessment be completed when there is a change continence status of a resident. RPN stated when the RAI-MDS assessment was completed at the end of the above mentioned quarterly period, the continence assessment should be completed for the resident. The RPN reviewed the clinical records of Resident #005 and indicated that a continence assessment was not completed when there was a change in bowel continence for resident #005. The RPN stated the staff did not follow the home's expectation regarding completion of the continence assessment when resident #005 had a change in the specified continence status.

Interview with ADOC #115, who is the Continence Lead for the home indicated it is the home's expectation for a continence assessment be completed when there is a change in continence status of a resident. The ADOC reviewed the clinical records of resident #005 and indicated that a continence assessment was not completed when there was a change in the specified continence status. The ADOC stated the staff did not follow the home's expectation regarding an incontinent resident receive an assessment. [s. 51. (2) (a)]

WN #15: 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 has failed to ensure that ensure that the appropriate police force was 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.

Review of a CIS report revealed RN #117 reported an alleged staff to resident abuse to the home on an identified date related to increased identified injuries of unknown cause that involved resident #032, #033, #034, #035, and #036. The CIS report indicated the residents' injuries on an identified home area coincided with a staff member assigned to the home area, and the staff member was off work pending investigation. Further review of the CIS report indicated the home submitted the CIS report on the same day and no police force was notified.

Review of the progress notes indicated on different identified dates, the above mentioned residents sustained different identified injuries.

Interview with RN #117 indicated he/she suspected abuse had happened after the above mentioned PSW started working on the unit and having increase number of the identified injuries of unknown causes on residents. RN #117 reported it to the home on the same date that the home submitted the CIS report, and RN #117 was not aware if the home had notified the police force.

Interview with ADOC #115 indicated he/she is one of the responsible staff members for reporting critical incident to the MOHLTC and notifying appropriate police force when it may constitute a criminal offence. The ADOC reported the above mentioned alleged abuse to the MOHLTC because there was reasonable to ground to suspect staff to resident abuse had happened and that led to resident injuries. The ADOC confirmed the alleged abuse may constitute a criminal offence, and the appropriate police force should be notified, but they were not. [s. 98.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
- A description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident.

Review of a CIS report revealed that on an identified date, resident #039 fell when a PSW was providing a specified care to the resident at the time of the fall. The resident was sent to hospital on the same day. As a result, the resident sustained an identified significant injury and returned to the home after an identified medical treatment. The CIS report was first submitted to the MOHLTC the next day after the resident fell and was amended on an identified date one month later. The name of the PSW was not reported on the CIS report.

Interviews with the DOC and the ED indicated the incident had happened, and the DOC confirmed that the CIS report did not include the name of the above mentioned PSW who was present at the incident. [s. 107. (4) 2. ii.]

Issued on this 2nd day of November, 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) :	MATTHEW CHIU (565), JOVAIRIA AWAN (648), JOY IERACI (665), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2017_650565_0010
Log No. / No de registre :	011001-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 17, 2017
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy VanBeek

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan. The plan shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #007's behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The plan must include but not be limited to:

1) Develop procedures and interventions to respond to resident #007's identified responsive behaviours. The procedures and interventions must be implemented to ensure that co-residents remain safe and are not subject to resident #007 entering co resident rooms.
2) Develop procedures and interventions to ensure all staff, including 1:1 staff are able to intervene and deescalate situations when resident #007 displays signs of heightened behaviours.

Please submit the plan to shihana.rumzi@ontario.ca, by October 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm

or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and amongst residents.

a. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) Director, related to abuse. The CIS report stated that on an identified date, resident #007 demonstrated identified responsive behaviours towards an identified Personal Support Worker (PSW) who performing a specified PSW care. The identified PSW attempted an identified intervention which made resident #007 increasingly agitated and the PSW required assistance from the nurse. As the PSW stepped away, resident #007 had an identified interaction towards resident #008 who was walking towards him/her to get to his/her room, causing resident #008 to fall and sustained an identified injury.

Record review for resident #007 indicated he/she was admitted to the home on an identified date and was transferred to hospital on another identified date.

A review of resident #007's written plan of care revealed an identified responsive behaviour focus. Further record review indicated specified direction was given to PSW for the specified PSW care when on duty with resident #007.

Inspector #604 attempted to interview resident #008 and the resident indicated he/she is unable to recall any information related to the incident above and he/she was doing well.

An interview with PSW #114 confirmed he/she worked on the day of the above mentioned incident and stated he/she is aware of resident #007 who has responsive behaviours. The PSW stated resident #007 can have no behaviours on one day but demonstrating identified responsive behaviours on the other day by demonstrating identified interactions. The PSW added that resident #007 had a specified PSW care a few weeks after his/her admission to the home as he/she began to show signs of the identified responsive behaviours. The home utilized the specified PSW care on all shifts to addressing the resident's responsive behaviours. The PSW stated when the resident demonstrates the identified responsive behaviours, certain identified strategy would be used by the PSW who performing the specified PSW care to the resident.

An interview with Registered Practical Nurse (RPN) #126 confirmed he/she

worked on the day of the above mentioned incident and recalls the incident which occurred between resident #007 and #008 as indicated above. The RPN stated resident #007 had unpredictable identified responsive behaviours towards staff and other residents in the home and had the specified PSW care on all three shifts. The RPN stated when resident #007 demonstrated the identified interaction towards resident #008, it caused the resident to fall down to the floor and sustaining an identified injury. The RPN stated the PSW, who was performing the specified PSW care for resident #007, was attempting an identified intervention which triggered the resident's increased identified responsive behaviours.

An interview conducted with PSW #128 confirmed he/she worked on the day of the above mentioned incident and was the PSW performing the specified PSW care for resident #007 for that shift. The PSW indicated the resident had the identified responsive behaviours. The PSW stated he/she recalls the incident as indicated above and when resident #007 demonstrated the identified responsive behaviours towards resident #008, it caused resident #008 to fall down to the floor and sustained the identified injury. The PSW indicated that the home had the specified PSW care for resident #007 but the PSW was unable to redirect the resident when he/she demonstrated the identified responsive behaviours, and the PSW stated the strategies were not effective most time.

b. A second incident involving resident #007 was reported to the MOHLTC Director related to abuse through a CIS report. The CIS report indicated that on an identified date, resident #007 demonstrated an identified responsive behaviours in the room of resident #009 and #010 who shared the same room. Resident #009, #010 and an identified PSW, who was performing a specified PSW care to resident #007, intervened with identified interventions. Subsequently, resident #007 demonstrated an identified action causing resident #009 to fall and sustained identified injuries, and resident #010 was hit but no injuries were identified at the time of the incident. The PSW was able to redirect resident #007 down the hall but resident #007 continued demonstrating identified responsive behaviours towards the PSW.

A review of resident #007's written plan of care indicated an identified responsive behaviours focus. The focuses and interventions are identified as above mentioned.

An interview with resident #010 confirmed the above incident occurred and

stated he/she did not have any injuries. The resident stated that the identified PSW who was with resident #007 could not handle the resident when he/she would demonstrate the identified responsive behaviours.

An interview with resident #009 confirmed the above incident occurred and stated that resident #010 was in the room as they shared the room. The resident stated he/she saw resident #007 coming and resident #010 attempted an identified action. Subsequently, resident #007 demonstrated identified responsive behaviours and actions towards resident #009 and #010. As a result, resident #009 fell and had pain. The resident indicated resident #007 had been demonstrating identified responsive behaviours and the resident has a specified PSW care all the time but the PSW performing the specified PSW care can't handle the resident's identified responsive behaviours.

Inspector #604 was unable to interview PSW #161 who was witness to the incident as indicated above.

An interview with RPN #127 confirmed he/she worked on the day of the above mentioned incident. The RPN stated resident #007 would demonstrate the identified responsive behaviours, and monitoring the resident was the only the strategy in place for the PSW, who performs the specified PSW care to the resident, when he/she demonstrated the behaviours. The RPN stated he/she is aware of the above incident and acknowledged that resident #009 sustained an identified injury when he/she fell, and resident #010 sustained no visible injuries.

An interview with Registered Nurse (RN) #158 confirmed the above mentioned incident had happened. The RN stated that the PSW, who performed the specified PSW care to resident #007, was unable to control or redirect resident #007. The RN stated resident #007 presented with the identified responsive behaviours. The RN stated resident #009 sustained the identified injury and resident #010 had no visible injuries. Both residents were distraught and visually upset.

An interview with the home's Behavioural Support Resource Team (BSRT) Lead #144 indicated shortly after resident #007 was admitted, the resident was noticed to present the identified responsive behaviours. The BSRT Lead indicated when resident #007 demonstrated identified responsive behaviours, the PSW performing the specified PSW care would intervene with identified interventions. The BSRT Lead indicated he/she was aware of the two incidents

mentioned above, where resident #008 and #009 sustained identified injuries.

An interview with the Director of Care (DOC) indicated he/she is was aware of the above two incidents that involving resident #007. The DOC stated the home had the specified PSW care with resident #007 as his/her presented with unpredictable responsive behaviours and the home had placed the specified PSW care to ensure resident #007 and other residents in the home were safe. The DOC stated the home had identified specialized in-home and outside resources involved to assess resident #007's responsive behaviours. The DOC stated resident #007's actions caused resident #008 and #009 sustained identified injuries.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual. During the course of the inspection the inspectors inspected six CIS reports related to responsive behaviours in the home. A review of resident #007's written plan of care did not show evidence of the home developing effective procedures and interventions to address resident #007's identified responsive behaviours and also for the identified trigger. The written plan of care indicated triggers but did not have interventions put in place to minimize the risk of altercations and potentially harmful interactions between and amongst residents. Resident #007 demonstrated identified responsive behaviours towards resident #008 and #009 causing them to sustain the identified injuries as above mentioned.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that there have been previous non-compliances related to the Long-Term Care Homes Act O.Reg. s.55, which is as follows:

1) 2016_268604_0015, Resident Quality Inspection in June 20, 2016 – CO was issued. [s. 55. (a)] (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 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, commercial courier or by fax upon:

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

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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Matthew Chiu

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