Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_621547_0016	020148-17, 023639-17, 024254-17, 025569-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 5, 6, 11, 12, 13, and November 10, 2017

This inspection was conducted regarding written complaints and Critical Incident Reports (CIR) submitted by the home regarding care and services for resident #001 on four separate occasions:

Log # 020148-17 written complaint to the home was related to concerns of continence care management and infection control issues,
Log # 024254-17 written complaint to the home was related to concerns of sleep and rest routines and staff not following the resident's plan of care,
Log # 023639-17 critical incident regarding alleged staff to resident neglect reported and
Log # 025569-17 critical incident regarding alleged staff to resident physical abuse

During the course of the inspection, the inspector(s) spoke with residents, a family member, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, the Office Manager, the Program Manager for Resident Care (PMRC) and the Program Manager for Personal Care (PMPC), and the Administrator.

In addition, over the course of the inspection, the inspector interviewed staff, reviewed residents' health care records, reviewed staff work routines, observed resident rooms and resident common areas, reviewed documents related to the home's investigations into CIR logs #023639 and #025569-17, as well as written complaint logs #020148 and #024254-17. The Inspector reviewed policies related to Abuse, Complaints and Lifting / Transferring Program. The inspector observed the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Neglect is defined as per O.Reg. 79/10 s. 5. as:

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

Log #020148-17

This inspection is related to written complaint given to the home on a specified date by the Substitute Decision Maker (SDM) for resident #001. This complaint documented concerns regarding continence care and infection prevention related to the delayed treatment for a urinary tract infection for the resident. This complaint also documented concerns related to personal care and services provided to the resident by nursing staff in the home.

Resident #001 was admitted to the home on a specified date with several medical diagnoses including a specified cognitive impairment, anxiety and a joint disease to multiple areas.

On October 5, 2017 Inspector #547 reviewed resident #001's health care records and observed the following documentation in the resident current plan of care:

- Resident #001 has had responsive behaviours since admission to the home, in that the resident resists personal care and hygiene with physical and verbal aggression, requiring two staff or more, to assist with all personal care. This includes transfers, repositioning, mobility and toileting,
- Resident #001 requires hygiene care to be provided with one to two person assistance, depending on the resident's responsive behaviours,
- Resident #001 is hard of hearing to his/her left ear and needs to be spoken to softly in the opposite ear in short simple phrases,
- Resident #001 was admitted as being incontinent for bowel and bladder, requiring briefs to be applied at all times and changed as required by two or more staff members,
- Resident #001 was also identified on the home's initial skin assessment as high risk for impaired skin integrity issues related to impaired mobility, dementia and incontinence.

The resident's care plan utilized in the month of September 2017, indicated over 42 interventions identified by registered nursing staff, geriatric psychiatry consultations, and

the resident’s SDM to assist in management of the resident’s responsive behaviours. Despite these interventions in place, behaviours were documented in the resident’ progress notes, resident care flow sheets and the unit's 24 hour report book almost daily as not manageable or personal care was refused. Resident #001’s hearing and communication plan of care identified that the resident’s decreased hearing ability combined with resident’s short and long term memory loss and marked decrease in decision making abilities, impacted the resident’s resistance to personal care.

Resident #001's physician orders documented an order on a specified date, to obtain a urine specimen for suspicion of urinary tract infection. No urine specimen was taken from the resident. Three days later, nursing staff discovered that this urine specimen was not collected. The urine specimen was collected however it had to wait another two days to be sent to the lab due to a holiday weekend. The urine specimen results returned to the home two days after this,with positive results for urinary tract infection. The physician was made aware of the positive test results the next day however the physician decided not to treat the resident based on the fact the resident was reported to be asymptomatic for infection. The home was not able to locate any documentation to indicate that the resident’s SDM was made aware of these urine test results or the physician's assessment not to treat.

Inspector #547 reviewed the resident's SDM's written complaint, that identified a specified date, the resident’s SDM arrived to the home after lunch to find the resident in bed. A foul odour of urine was noted in the resident’s bedroom. The resident was in bed shivering, indicated to the SDM that he/she was cold and had pain in the legs. The resident’s SDM asked the registered nursing staff to assess the resident. The registered nursing staff recalled the resident had positive urine specimen results and called the physician. An order for antibiotics was made, 15 days after the initial suspicion of a urinary tract infection was noted for the resident. The registered nursing staff returned to the resident's room and noted the foul odour of urine in the resident’s room. The registered nursing staff located the smell to come from the resident’s wheelchair cushion. Upon lifting the resident’s wheelchair cushion, it was observed to be saturated and leaking yellow fluid that the registered nursing staff indicated to the SDM to be urine.

The home’s investigation to this written complaint revealed that the resident's extra absorbent brief was still dry in the morning of this specified incident. The nursing staff were not required to change the resident's brief. The nursing staff returned the resident to bed after lunch with the resident's brief and clothing saturated with urine. Staff indicated to the registered nursing staff they did not notice any foul odour of urine after nursing

care was provided to the resident and the resident's wheelchair seat cushion was not verified.

On October 6, 2017 upon arrival to the resident's nursing unit, PSW #101 and #102 indicated to Inspector #547 before the end of their shift, that the resident had his/her brief changed that morning but had refused to have his/her brief changed after lunch as required. PSW #101 and #102 were reporting this to RN #100. RN #100 indicated to Inspector #547 and the PSW's that she would report this to the evening shift nursing staff. PSW #101 and #102 indicated that this is a regular behaviour for this resident as the resident often refuses personal care related to changing of a brief. PSW #103 indicated that the resident refuses to have his/her brief changed often, so when they do finally change the resident's brief, the resident's clothing and seat cushion are frequently completely saturated in urine.

On October 11, 2017 RN #100 indicated that resident #001's brief change pattern was to have his/her brief changed before getting up in the morning. The resident wears a super absorbent brief at night, that is applied in the evening. The resident's brief is not changed at all during the night in order to not disturb the resident's sleep pattern. Once the resident is up in his/her wheelchair, nursing staff monitor the resident for any incontinence signs otherwise the resident's brief is changed a second time after lunch. The resident no longer is toileted and is transferred to bed for the brief to be changed. The resident is then positioned back in his/her chair and the evening staff verify his/her brief to see if it requires to be changed before supper. The resident's brief is then changed at bedtime at a specified time for the night. RN #100 indicated that the resident is at high risk for impaired skin integrity, however resists care regularly and is often saturated in urine related to refusing to be changed. RN #100 further indicated that the resident's behaviour related to changing of the continence care products likely contributed to this infection, as the resident is often seated for many hours in his/her wheelchair with a soiled brief, which might contribute to the resident being at risk for urinary tract infections.

As such, the resident's continence care and comfort were not managed until 15 days after the initial concern for urinary tract infection was assessed by the nursing staff in the home.

Log # 024254-17

This inspection is related to a written complaints by resident #001's SDM to the home's

Administrator on another specified date, regarding care and services provided to resident #001 on specified evening and night shifts. The SDM identified a concern for resident #001's lack of care and services provided to the resident regarding the nursing staff leaving the resident seated in his/her wheelchair until the middle of the night shift and then care was provided by a male staff member. The resident's plan of care specifically indicated the resident is to receive care by a female nursing staff member only. The SDM further identified a concern that on the following evening, the SDM had to call the registered nursing staff to intervene with the resident's care being provided as it was already a later specified time in the evening. The resident was not in bed and the SDM was concerned that the resident would remain in the wheelchair as the previous night.

Resident progress notes and continence care flow sheets were reviewed for the following instances where the resident was noted to refuse to have the continence products changed:

a) documentation indicated the resident received continence care on the evening shift at a specified time on a specified date. The resident did not have any documented care provided over the night shift as per care plan. The resident refused to have personal care all day and evening the next day. The resident did not have any documented care provided over night as per care plan and the continence flow sheet documented that the resident's brief was changed during the day shift and personal care was then provided. As per this documentation, the resident had not received personal care for a period of approximately 36 hours.

b) documentation indicated the resident's continence product was changed and personal care was provided during the evening shift on a specified date. The resident did not have any documented care provided over the night shift as per care plan. The resident refused to have his/her continence product changed all day or personal care provided. The resident stayed in bed until staff got the resident up in the evening for the supper meal, however refused to have the continence product changed or personal care provided. The resident refused to be returned to bed at a specified time in the evening as required. The progress notes for the night shift indicated that the resident had remained in his/her wheelchair all night as he/she refused to be transferred to bed. The resident was transferred to bed and personal care was documented in the flow sheets as provided. As per this documentation, the resident had not received personal care for a period of approximately 35 hours.

c) documentation indicated that the resident refused to have his/her continence product

changed or personal care provided during the day shift however staff were able to get the resident up for meals on a specified date. The resident refused to be transferred to bed by evening staff or to have the continence product changed. The resident remained dressed, unchanged in day clothes and soiled continence products for over 16 hours. The evening staff on the following date identified the resident now had reddened skin on the buttocks.

d) documentation indicated that the resident refused to have his/her continence product changed all evening and stayed in his/her wheelchair. Night shift documented the resident remained in his/her wheelchair until the middle of the night. Care was then provided after over 12 hours in soiled continence product. The resident then remained in bed all the next day and refused personal care until before the evening shift. As per this documentation, the resident had not received personal care for another period of approximately 12 hours. On a specified date following these incidents, resident #001 was documented to have reddened skin on the buttocks.

Log # 023639-17

This inspection is related to a verbal complaint by resident #001's SDM to the home's Administrator on a specified date, of an alleged staff to resident incident of neglect that occurred during the evening and night of a specified date. The home submitted a critical incident report of alleged neglect that occurred whereby resident #001 refused to go to bed at a specified time on an evening and was left in his/her wheelchair all night until after breakfast on the following day. The SDM identified concern for resident #001's lack of care and services in that staff did not provide the essential personal care needs for continence, hygiene, comfort or sleep and rest routines for the resident as required in the resident's plan of care.

On October 6, 11, 12 and 13, 2017, Inspector #547 reviewed resident #001's health care records. Documentation over a specified 11 day period identified the following:

- documentation indicated resident #001 had personal care provided and brief changed at a specified time at the beginning of the evening shift. The resident refused to be transferred to bed that evening as documented in the progress notes. No documentation for the night shift was found in regards to the resident's responsive behaviours or the provision of care. The resident remained in his/her wheelchair during the night shift. The resident went to breakfast the next day and then was transferred to bed, approximately 17 hours after the last provision of personal care.

- documentation indicated a care conference with the resident's SDM was held to discuss behavioural approaches for personal care and to review the resident's sleep pattern and preferences. A decision and a plan were developed to ensure that the resident is to be up on day shift every morning at 0800 hours and returned to bed at night at 2000 hours. Strategies and plans were developed to ensure that staff perform personal care for continence care products with one staff member, as too many staff working in the resident's room makes the resident agitated and aggressive. Clarifications were added regarding nursing staff are to attempt to change the resident once, if the resident refuses, staff are to leave the resident and return after a few minutes and attempt a second time. If the resident refuses the second time, leave the resident and return after a few minutes to then provide the care required. Registered nursing staff are to call the resident SDM if the resident has physically aggressive behaviour when attempting to provide personal care. Strategies for the residents hearing difficulties and the intervention of no male staff to provide the resident personal care, were reinforced.

- the following day, the resident's progress notes documented that the resident refused personal care on the evening shift and refused supper meal. The progress notes from the night shift documented that the resident was transferred to bed at some point during this shift. The following day, the resident's progress notes documented that the resident refused to have his/her continence product changed after lunch. The resident was transferred to bed at a specified time, whereby the resident's continence product was changed after approximately 12 hours in the same brief.

-Five days later, the resident progress notes documented at the end of the evening shift that the resident refused evening medications and refused to have his/her brief changed. Behaviour mapping tool started for the resident's behaviours. Night shift documented that the resident refused to have his/her brief changed after two attempts even when the resident had had a bowel movement. The resident's continence product was not changed nor was personal care provided to the resident for approximately 16 hours.

On October 11, 2017 Inspector #547 interviewed RN #100 who indicated that nursing staff are not able to provide the care the resident needed due to the resident's responsive behaviours. RN #100 further indicated that the issue of staff not transferring the resident to bed at night and leaving the resident in a wheelchair all night or almost all night in the last few weeks was not acceptable.

On October 13,2017 Inspector #547 interviewed PSW #101 who indicated that she was

able to provide the resident care when she was working on her own most of the time. The PSW stated that she finds it neglectful to not provide the resident personal care as the resident needs it, but it was not for a lack of trying to provide it to the resident.

Inspector #547 interviewed PSW #101, #102, #103 and #104 who indicated that they thought that it was unacceptable that resident #001 was left overnight in a wheelchair. PSW #102 indicated that she works with the Behaviour Supports Ontario (BSO) team and that sometimes they have to be three staff members to assist in changing the resident now that they have to do the care no matter if the resident refuses. The resident often will spit and hit them during care, and staff are afraid to get hurt. PSW #102 further indicated that staff are afraid to hurt the resident as well, as now they are to do the care even if the resident refuses or becomes physically resistive to care. PSW #101 indicated that she was concerned with the resident's resistance to care, and would like to be shown alternative methods to provide care safely for both the resident and nursing staff versus forced care.

On October 13, 2017 Inspector #547 asked the PMRC and PMCC what they had done to manage the ongoing complaints from the SDM. The SDM had identified in several interdisciplinary meetings that were held since the beginning of 2017 regarding resident #001's responsive behaviours, hearing loss issues and personal care provision. The PMRC indicated that the physician did attempt to check the resident’s ears on two separate occasions in 2017, but the resident refused, and was assessed by the external audiologist. The PMRC and PMCC further indicated that they had not re-evaluated if the care was being provided or assessed if staff were using the identified plan of care approaches with resident #001, as they assumed that registered nursing staff were doing this on the unit. The PMCC indicated that she had not given the PSW’s on the resident’s unit any education or direction on how to safely manage the resident’s behaviours but to do the best they can. The PMCC and PMRC indicated that they were not aware of any geriatric psychiatry reassessment with resident #001's responsive behaviours since a specified date, regarding provision of personal care.

As such, the resident's plan of care regarding sleep and rest patterns was not followed which mixed up the day and night routines for the resident. This issue with sleep and rest patterns then affected the necessary nourishment, hydration needs and provision of prescribed medications for the resident due to fatigue. The nursing staff failed to provide resident #001 personal care as well as continence care management. Resident #001 was left seated in an adaptive wheelchair for long periods of time, with no documented repositioning or continence care provided posing infection and skin integrity risks for this

resident. [s. 19. (1)]

2. The licensee has failed to ensure that resident #001 was protected from abuse by anyone and free from physical abuse by staff in the home.

Physical abuse is defined as per O.Reg, 79/10:
" s.2.(1) physical abuse means,

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

s.2. (2) specified for the purposes of clause a of the definition in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances."

On a specified date, resident #001's SDM provided the Administrator evidence regarding concern about care provided to resident #001 the day before. The evidence was reviewed by Inspector #547 on November 10, 2017.

-The evidence identified morning personal care was provided to resident #001 by PSW #113 and PSW #116. Washing, changing the resident's continence brief and dressing was completed in order to transfer the resident to his/her wheelchair for breakfast.

The resident's arms were noted to be pushing PSW #113 away during personal care, however PSW #113 proceeded to wash the resident and change the resident's continence brief. PSW #116 remained at the resident's other side of the bed, assisting by holding the resident's arm from hitting PSW #113, dressing and changing the resident's continence brief. Both PSW's then proceeded to transfer the resident from lying to sitting and repositioned the resident inappropriately and with excessive force. The evidence demonstrated inappropriate transfer techniques provided by PSW #113 and PSW #116 by using excessive force when transferring resident #001 from his/her bed to wheelchair, that jeopardized the resident's safety from falls or injury as identified in this report in WN #3.

-The evidence further identified afternoon personal care on this same day, whereby three PSW's applied a specified lift transfer sling roughly on the resident and when applying the sling hooks to the lift device. The evidence further demonstrated rough physical care

by the three PSW's in changing of the resident's top also identified in this report in WN #3.

PSW #116 indicated to Inspector #547 during an interview regarding this evidence, that she was not familiar with the resident's plan of care as she had never provided the resident personal care before. PSW #116 indicated that she was following PSW #113's lead, as she was familiar with the resident's care needs. PSW #116 indicated that the resident's transfer was difficult during the morning care, as the resident did not weight bear at all, and they had to pull the resident's pants up and drag the resident to his/her wheelchair to prevent the resident from falling to the floor. PSW #116 indicated that they dropped the resident into the wheelchair related to the resident's weight and their positioning during this transfer. PSW #116 indicated that she found the afternoon care that was provided by three PSW's was rough on the resident. PSW #116 did not report these incidents to any registered nursing staff.

PSW #101 indicated to Inspector #547 during an interview regarding the afternoon personal care on this specified date, that she would not have chosen this transfer method for the resident. PSW #101 indicated the resident does not like this lift and always becomes aggressive. PSW #101 indicated to be following PSW #113's lead in this transfer, as PSW #113 was the nursing staff assigned the resident for that day. PSW #101 indicated that this transfer method is identified in the plan of care, but it shouldn't as it is not effective for the resident. She would have transferred the resident to bed, and then changed the resident's continence product with 1 staff member, to not overwhelm the resident.

The resident's SDM indicated to Inspector #547 that the resident complained of pain to the left buttocks in the days after these incidents related to the rough care provided during transfers.

The Administrator indicated to Inspector #547 that three PSW's were placed on administrative leave after she reviewed the evidence provided by the resident's SDM. She indicated that excessive force of pulling, dragging of the resident and the roughness in care was observed during the morning and afternoon care on this specified date and an investigation was immediately started. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
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 licensee fully respected and promoted resident #001's right to give or refuse consent to any treatment, care or services for which consent is required by law and to be informed of the consequences of giving or refusing consent.

Resident #001 was admitted to the home on a specified date with several medical diagnoses. On admission, resident #001's condition was such that all the decision making regarding resident care was done by the SDM.

On a specified date, resident #001 physician orders prescribed a regular dose of a medication to be given every morning for two weeks at 0600 hours. The resident's Medication Administration Record (MAR) documented this medication was given to the resident during this two week period.

On October 6, 2017 Inspector #547 reviewed the resident's health care records and no documentation was found to indicate the resident's SDM was informed of the change in the plan of care for medications during this specified period.

The following specified month, the physician progress notes documented a meeting held with the SDM that indicated that this specified medication had been given to resident #001 for a two week period in the previous month, without consent and the home's physician apologized for this oversight.

On October 11, 2017 the Program Manager of Personal Care (PMPC) indicated to Inspector #547 that the registered nursing staff who received this order did not inform the resident's SDM of this prescribed medication as change to the resident's plan of care as required for consent. [s. 3. (1) 11. ii.]

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 Licensee fully respects and promotes resident #001's SDM right to give or refuse consent to any treatment, care or services for which consent is required by law for medications, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001.

Resident #001 with diagnosed with a specified cognitive impairment and anxiety. Resident #001 requires adaptive approaches regarding resistance to personal care

needs.

Resident #001's SDM provided evidence to the home's Administrator on a specified date regarding concerns of care provided to the resident on three occasions on a specified date.

On this specified date, the evidence identified three incidents when personal care was being provided to resident #001 as follows:

A) Morning care was provided to resident #001 by PSW #113 and PSW #116. Resident #001 was in bed and resisting personal care provided by both PSW's. PSW #113 tried to turn the resident from side to side in order for PSW #116 to provide personal care, however the resident pushed the PSW's hands away several times. PSW #113 then pulled the resident's nightgown up over the resident's hands and arms to restrain the resident's hands from preventing the PSW's in providing personal care.

The Program Manager of resident Care (PMRC) provided inspector #547 the resident's plan of care/Kardex which identified the Activities of Daily Living (ADL) needs as per the following care interventions:

1.Bed Mobility: considerable assistance of 2 persons
2.Personal Hygiene: total assistance, one person in the resident's field of vision, and to speak to the resident in her right ear with short and simple sentences.

B) Afternoon care was provided by PSWs #101, #113 and #116 on this same date. This evidence showed three PSW's working with the resident at the same time to prepare resident #001 to use a specified lift device. The resident appeared to be anxious and confused and became agitated by the care being provided. The resident was restrained in the specified lift device, with PSW #101 providing assistance of holding the resident's arms and then hands to the lift outside the lift sling, in order for PSWs #113 and #116 to provide personal care and change the resident's continence product. The resident was very agitated, moving his/her head from side to side during this care. Once the resident was re-seated in the wheelchair, PSW #101 and PSW #113 attempted to change the resident's top. PSW #101 was holding the resident's hands from behind the resident, and PSW #113 pulled the resident's cardigan up from behind the resident's head. PSW #116 then approached the resident from the front to assist in the removal of the resident's cardigan and night wear clothing. The resident became anxious and agitated resisting the three PSW's from the care that they were providing. The resident was talking to each

the three PSW's standing in front of the resident, yet they did not respond and continued to try to apply a sweater over the resident's head. PSW #113 then obtained an adaptive top in the resident's room after attempting to apply a sweater over the resident's head several times. The adapted top was applied without resistance from the resident.

C) The evening personal care was provided to resident #001 by one PSW on this same date. This PSW provided personal care and changed the resident's continence product while the resident was in bed. The PSW was able to provide hand gestures to the resident, and successfully was able to change the resident's continence product, and turned the resident from side to side several times to adjust the continence brief and night wear clothing for comfort. The second PSW remained inside the resident's bathroom attached to the bedroom, with the door open, giving direct viewing to the care being provided by the other PSW at the resident's bedside ensuring if needed, the PSW could provided assistance as required. The resident smiled during this personal care instance and gave the PSW a thumbs up when the personal care was completed. The second PSW then approached the resident's bedside, and waved with a smile to the resident.

The resident's health care records documented a care conference held with the PMRC, Administrator, Resident #001's SDM and RN #108 approximately 4 weeks earlier from this said date. This care conference was regarding personal care approaches that were to be changed in the resident's plan of care. The progress notes identified that the resident required two persons assistance for pivot transfer, and then one person is to provide the resident personal care and the other staff member would stand out of sight of the resident's field of vision, for less distraction and noise for the resident. This information was not clearly identified in the resident's plan of care for staff direction.

Inspector #547 went to the resident's unit two days after this care conference,and nursing staff for the evening shift were receiving verbal directions from RN #100 regarding the personal care approaches required for resident #001 as identified in that care conference. RN #100 indicated to transfer resident #001 with two persons and then to provide care with one person. If the resident refuses care, staff are to leave the resident and return a second time. If the resident refused again the second time, staff are to leave the resident and return a third time and provide care required. RN #100 reinforced with the nursing team that these approaches and staff direction was in to the resident's plan of care.

On October 12, 2017 PSW #101 indicated to Inspector #547 that nursing staff are afraid

to hurt the resident, or get hurt by the resident during personal care. The PSW expressed that they and other nursing staff are afraid of what is possibly misunderstood on video, and many would rather not do care if forced as they feel this to be wrong. PSW #101 further indicated the resident should not have to stay in a soiled brief, but admitted that this does happen because of the resident's responsive behaviours. PSW #101 indicated nursing staff were not shown methods on how to provide the care as per the care conference regarding directions when the resident refuses care for the third time, so they just do what they can to get the resident's care done.

On November 10, 2017 the Administrator indicated to Inspector #547 that the resident had a bag of adapted clothing the resident's SDM had provided the home as requested over a month ago, that were inside the resident's room in a bag, however were not placed in the resident's closet or information added to the plan of care regarding these adaptive clothing were to be used to dress the resident. The Administrator further indicated that the resident's plan of care did not provide clear directions to nursing staff to use these adaptive approaches in the provision of the resident's plan of care, and that the care plan was being updated by both Program Managers for nursing in the home.

On November 10, 2017 the PMPC indicated to Inspector #547 that upon her review of the resident's health care records between two specified dates, no request was made to the home's psychogeriatrics team to assist or review various approaches on how to provide the resident personal care. The PMRC indicated during this same interview, that management assumed that the registered nurse on the resident's unit was ensuring that the information related to the provision of personal care was clearly identified in the resident's plan of care. The PMRC and PMPC indicated to Inspector #547 they were updating the resident's plan of care to ensure that nursing staff had clear directions on the various approaches required for resident #001's, before the end of day. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001 related to Urinary Tract Infection (UTI), hearing deficit, and revision of care interventions for responsive behaviours, so that their assessments are integrated, consistent with and complement each other.

A.Issues related to UTI:

On a specified date, a progress note in the resident's health care records indicated that the resident was prescribed an order for a specialized procedure to obtain a urine

specimen for suspected UTI. This order was identified on the 0700-1500 hour shift. This order was not processed or any urine specimen obtained on the 0700-1500 hour shift. The order for urine specimen was not communicated on the 24 hour shift report book for the next shift. Three days later, the resident's urine had a strong odour and a urine specimen was obtained and was to be sent to the lab as it had not been completed when it was ordered three days earlier. The resident was observed on 1500-2300 hour shift to be leaning to the left side two days later, drowsy and another urine specimen was obtained and urine dip stick was completed that identified a positive infection results. This second specimen was also sent to the lab.

On a specified date ten days later, the resident was noted to have heavily saturated an extra absorbent continence product, to the point the resident's brief, clothing and wheelchair seat cushion were saturated in urine. This was not communicated to RPN #107 until the resident's SDM arrived and observed the resident to be in bed, not feeling well, complaining of pain, and foul odour of urine was noted in the resident's bedroom.

The resident's Physician #114 indicated to inspector #547 that he was covering physician the original specified date, when nursing staff suspected the resident had a UTI. The nursing staff requested a specialized procedure order to obtain a urine specimen for this resident who was incontinent for suspected UTI. He was not sure why the urine specimen was not obtained that day. The physician reviewed one of the lab analysis reports on a specified date, and noted positive results for infection. The physician asked registered nursing staff that day how the resident was acting, if there were any changes in the resident's behaviour were observed, they said no. The nursing staff reported to the physician that resident #001 always had behaviours however now presented with foul smelling urine. He indicated that this is often a sign of dehydration and contaminants can often affect urine samples, but since the only symptom communicated to the physician that was out of the ordinary for this resident was urine odour, he chose not to treat the resident. He was called again 15 days later by registered nursing staff, to indicate that the resident had chills and pain to legs, ongoing behaviours were present, positive lab results for UTI were reviewed again with the physician, and identified that the resident was having increased amount of urine with odours. The covering physician decided to treat with antibiotics based on symptoms that was provided to him at that time.

Nursing staff did not collaborate with each other or to the resident’s physician so that their assessments were integrated, consistent and compliment each other in detecting urinary continence and infection issues as required for resident #001.

B. Issues related to hearing deficit:

Resident #001 was admitted to the home with an identified hearing deficit that required adaptive approaches related to responsive behaviours.

Over the course of this inspection, PSW #102, #103 and #105 indicated that they will ask the resident if they can provide care to the resident, resident #001 will accept care, however once they bring the resident to the bedroom and try to begin personal care, the resident will resist and begin to hit, scratch and kick towards staff. PSW #105 indicated that many nursing staff will withdraw at this point, indicating the resident refused care.

Upon review of the resident's current plan of care, the resident's kardex identified the resident has poor hearing to the left ear, and to speak to the resident with visual contact with short simple phrases in a soft tone. A note was printed and attached to the kardex from a geriatric psychiatry assessment on a specified date over eight months earlier. This assessment identified the Behaviour Supports Ontario (BSO) PSW noted that when care is given to the resident in bed with two staff, that the resident responds best if the person facing the resident exclusively touches or speaks to the resident. This assessment further indicated this method was required otherwise the resident becomes responsive when the second person behind speaks or touches the resident.

On October 11, 2017 PSW #104 indicated to Inspector #547 and RN #100 that she always works with the resident on her own, as the resident does not like to have too many people in the resident's room, as it is hard for the resident to hear or understand. The PSW indicated that the resident can hear, however staff need to face the resident and speak slowly and calmly. The resident did well with hand gestures. The resident is able to turn from side to side, and hold on to the side rails with some assistance, if nursing staff explain calmly to the resident and ensure the resident understood what was asked. The PSW indicated the resident should never be rushed, and allow the resident to remain in control.

RN #100 indicated that she was not aware of this approach method related to use hand gestures to facilitate communication with the resident until now. PSW #104 further indicated that nobody had ever asked her about her approaches to care with the resident.

On October 11, 2017 the SDM indicated to Inspector #547 that he/she had not received any phone calls from the nursing staff regarding difficulty in providing the resident care.

The SDM indicated that he/she thought care must have been going better after their care conference meeting, when care interventions were reviewed and modified and that these changes were to be implemented. The SDM also indicated that the resident had his/her ears assessed by an audiologist finally. The audiologist indicated that the resident's ears were full of wax which was contributing to the resident's hearing loss. The SDM indicated to the registered nursing staff in the home, that he/she did not know why this test has taken a year to be done, when the SDM informed the home at admission, that the resident's ears required cleaning every six months for wax build-up. The SDM further indicated that the wax build up contributes to the resident's hearing loss. The SDM further indicated that the resident's hearing loss was identified as a trigger for the resident's behaviours, but the home had not managed this.

As such, nursing staff did not collaborate with each other so that their assessments were integrated, consistent and compliment each other in managing the resident's hearing deficit in relation to responsive behaviours.

C. Issues related to care interventions for responsive behaviours:

On October 11, 2017, Inspector #547 interviewed PSW #102, and #103, who indicated that they did not need to apply the specified adapted physical devices to resident #001, which was one of the identified approach interventions in the resident's plan of care. The PSW's indicated they were able to manage the resident's care with calm and clear specialized approach methods. PSW #103 indicated that some nursing staff do not have the same approach methods, and need to apply the specified adapted physical devices to the resident to prevent injuries. PSW #102 and #103 indicated they found these adaptive physical devices made the resident more anxious and aggressive during personal care. RN #100 indicated to Inspector #547 and the PSW's that she was not aware that some nursing staff were not using these adaptive physical devices during care or that this intervention made the resident more anxious and aggressive.

On October 11, 2017 PSW #104 indicated to Inspector #547 that resident #001's personal care is provided so that the resident's privacy is respected. PSW #104 indicated she will apply a towel across the resident's lower body and provide the resident a face cloth to assist with washing the resident's upper body. During this time, PSW #104 will lift the towel to provide personal care to the front of the resident's lower body. PSW #104 indicated that this technique for personal care has worked well. RN #100 indicated to Inspector #547 and PSW #104 that she was not aware of this approach method to assist the resident with personal care.

RN #100 indicated that when they develop the plan of care, they do not involve the PSW staff for their input regularly, and that as a team, the nursing staff should consult together more, to review interventions so that their assessments are integrated, consistent and compliment each other related to resident care provision. [s. 6. (4) (a)]

3. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #001's current plan of care identified nursing staff are to apply specified adaptive physical devices to resident #001 before providing personal care related to the residents responsive behaviours. These adaptive physical devices were identified by the Geriatric Psychiatry nurse for the home in an email from over eight months earlier that was printed and added to the kardex binder for resident #001. Nursing staff were directed to use these adaptive physical devices during personal care.

On October 5, 2017 Inspector #547 observed three of these specified adaptive physical devices in resident #001's room.

The resident's following progress notes regarding the use of these adapted physical devices indicated on:

On a specified date, RN #115 indicated the resident's SDM accepted the purchase of these adaptive physical devices for the resident to wear during personal care to prevent resident and staff injury during personal care.

Ten days later, RN #115 indicated that it is difficult to apply these adaptive physical devices, as resident #001 prevented nursing staff from being able to apply them safely. No reassessment of this intervention was identified in the resident's plan of care.

Three days later, the Resident Assessment Instrument (RAI) Coordinator documented that the nursing staff are unable to apply the specified adapted physical devices and that they make the resident more anxious and agitated. No indication this intervention was reassessed or updated in the resident's plan of care.

One month later, a Geriatric Psychiatry assessment indicated the home had tried these specified adapted physical devices, but they made the resident more restless and

combative during almost all attempts to provide personal care. No indication this intervention was reassessed or updated in the resident's plan of care.

The resident's current plan of care was reviewed by inspector #547, and observed that it continued to include the use of these specified adaptive physical devices when providing resident #001 personal care. No assessments and reassessments of these adaptive devices was documented and these items remain in her room for nursing staff to apply. [s. 6. (10) (b)]

4. The licensee has failed to ensure that resident #001 was reassessed and the plan of care revised because care set out in the plan related to continence management and responsive behaviours were not effective and required different approaches to be considered in the revision of that plan.

Resident #001 was admitted to the home on a specified date with several medical diagnoses including a specified cognitive impairment, anxiety and issues related to hearing loss. Resident #001's continence assessment at admission identified the resident to be incontinent to both bowel and bladder requiring use of medium size briefs to remain clean, dry and comfortable. Resident’s dementia needs required personal care to be provided by nursing staff at all times. Resident #001’s responsive behaviours were directly linked to resistance of receiving of personal care.

On October 6, 2017 inspector #547 reviewed the current kardex and care plan for the resident's continence and responsive behaviour needs which documented the following:

- the resident does not use the toilet,
- the resident wears a large incontinent brief during the day and evenings and is required to change the resident's brief at least one to two times during day shift, one to two times on evening shift if possible related to her responsive behaviours,
- the resident wears an extra absorbent large brief at bedtime. Do not change the resident at night and let the resident sleep,
- personal hygiene requires assistance of one to two staff members according to the resident's responsive behaviours and to apply adaptive physical devices to the resident before care is provided according to responsive behaviours,
- bed mobility identified the resident required considerable assistance of two staff related to responsive behaviours,
- care is to be provided by female staff members only related to responsive behaviours,
- hearing is weak in a specified ear and to speak towards the resident's opposite ear

while facing the resident with short simple phrases in soft voice linked to responsive behaviours,

On October 12, 2017 Inspector #547 reviewed resident #001's progress notes and resident care flow sheets documentation for the months for four specified months in 2017. It was noted the resident had responsive behaviours related to resistance of personal care almost daily by refusing to have his/her continence product changed for long periods of time. The interventions did not specify what nursing staff were supposed to do if the resident continued to refuse personal care as next steps. The resident’s hearing deficit had been identified to contribute to the resident’s aggressive behaviour combined with resident’s short and long term memory loss and marked decision making abilities, significantly impacted the resident’s resistance to personal care. Negative outcomes during this period related to this behaviour is summarized as follows:

1.The resident was documented to have had a urinary tract infection on a specified date in 2017. Documentation identified that several days prior to this diagnoses, the resident had strong odour of urine. The resident was further documented on this same date, to have had an extremely soiled brief and clothing, to a point that the resident’s seat cushion was saturated of urine and dripping when picked up by a registered nursing staff in company of the resident's SDM. The resident health care records identified almost daily to be aggressive during personal care and refuse the provision of care, despite interventions attempted that were not successful.

2. The resident was documented as having impaired skin integrity of a reddened buttocks on three specified dates in 2017.

3. The resident was documented to have remained in his/her wheelchair two specified nights in soiled briefs related to responsive behaviours.

4. The resident was documented to have remained in his/her wheelchair until the middle of a specified night shift and refused to have his/her brief changed during the evening shift. Resident #001 was in his/her wheelchair from when morning care was received the day previous until the middle of the following night on a specified date.

On October 6, 2017 Inspector #547 reviewed the home's investigation documentation from the resident’s SDM complaint regarding the care and services provided to resident #001 on a specified date. The documentation identified the PSW's working the 0700-1500 hour shift on this specific date, returned the resident to bed after lunch. The

resident was identified at that time to have his/her brief and pants saturated with urine. The resident had an absorbent brief that had been applied by the night shift nursing staff which had been assessed by the day nursing staff as being dry during morning care.

On October 11, 2017 PSW #101 indicated that the resident often refused to receive personal care, so by the time the nursing staff do provide the resident care, the resident is completely saturated with urine, and they have to change the resident's clothing, brief and seat cushion cover.

This report identified details about the above negative outcomes, as such, different approaches were not considered in the revision of the resident's plan of care to meet the resident's responsive behaviours needs for personal care requirements. This revision and different approaches were required to prevent further complications for infection, comfort/care, sleep and rest routines and impaired skin integrity issues. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001's plan of care set out clear directions to staff that provide direct care, to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001's needs, and that resident #001 was reassessed and the plan of care revised because care set out in the plan related to continence management and responsive behaviours were not effective and required different approaches to be considered in the revision of that plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs administered to the resident in accordance with the directions for use specified by the prescriber.

Resident #001 was prescribed a specified antidepressant twice daily as required(PRN) for anxiety, and the medication was not provided to the resident as directed by the physician to assist in the management of responsive behaviours.

On October 11, 2017 Inspector #547 reviewed the resident's Medication Administration Records (MAR) between a specified five month period and noted that the resident was administered this specified medication required for behaviours on four specified dates during this period.

On October 6, 2017 Inspector #547 interviewed RPN #105, who indicated that resident #001 was prescribed this specified medication for behaviours, but the resident's SDM refused staff to use this medication for the resident.

October 11, 2017 Inspector #547 interviewed RPN #106, who indicated that resident #001 did not have any PRN medication prescribed that she was aware of for anxiety. Inspector #547 and RPN #106 reviewed the resident's MAR together and she noticed that the resident is prescribed this specified medication and indicated that she did not think they were allowed to give this medication to the resident and that the resident has never received the specified medication in a specified month.

On October 11, 2017 RN #100 reviewed the MAR's for three consecutive specified months in the residents medical health records, and indicated that the resident was not administered any of these specified medications in these months.

Inspector #547 noted that these are the only four entries for the medication administration of this specified medication for anxiety during this five month period. The resident's health care records as identified in this report in WN #1, the resident had responsive behaviours almost daily identified during this period. The prescribed medication was not provided as prescribed over this period, to assist in the management of the resident's responsive behaviours in order to provide the resident personal care. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to the resident in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Program Manager of Resident Care (PMRC), identified the licensee's policy to promote zero tolerance of abuse and neglect, as policy #750.65 titled Abuse, last revised June 2017.

This policy stated "Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from other residents, families, volunteers or employees".

The failure to provide resident #001 with the appropriate assistance required for the resident's activities of daily living such as continence, personal care, sleep and rest routines identified in WN #1 of this report, included a pattern of inaction and excessive force that jeopardized resident #001's health, safety and well-being. In this way, resident #001 was subjected to abuse and neglect by nursing staff, that are employee's of the Licensee, who did not comply with policy #750.65. [s. 20. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure to immediately forward all written complaints that were received concerning the care of resident #001 and the operation of the home to the Director.

A written complaint was provided to the Licensee on specified date, regarding the care that was not provided to resident #001 for a 15 day specified period. This complaint was regarding care, services and infection prevention issues. Upon review of this complaint and response by the Licensee, it was noted that this written complaint was forwarded on to the Director, 11 days after the Licensee received the written complaint.

A second written complaint provided to the Licensee on a later specified date, regarding care not being provided to resident #001 during two consecutive shifts on specified dates. The complaint and response was reviewed during this inspection, it was noted that the written complaint was forwarded to the Director, eight days after the Licensee received the written complaint. [s. 22. (1)]

WN #7: 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 use safe transferring and positioning devices or techniques when assisting resident #001.

Resident #001 is diagnosed with specified cognitive impairment and anxiety
.
On a specified date, the resident's SDM provided evidence to the Administrator about concerns regarding resident #001's morning care from the previous day.

On November 10, 2017 Inspector #547 reviewed the evidence that was provided to the Administrator. PSW #113 and PSW #116 transferred resident #001 from bed to wheelchair, after morning care was provided. PSW #113 attempted to pull the resident with his/her arms from a lying position to a seated position in bed, however the resident was noted to be pulling away from PSW #113. PSW #116 went to the resident's head of

the bed on the same side as PSW #113, to assist in pushing the resident into a seated position, while PSW #113 pulled on the resident's left arm. Both PSW's then pulled the resident off the mattress. The resident was non-weight bearing at that time. The PSW's continued the two person pivot transfer despite the resident not weight bearing by holding the resident under each armpit, and by pulling up the resident's pants over his/her continence brief during this pivot transfer. The resident was dropped into a wheelchair abruptly, with the resident's back hitting the back of the wheelchair, with his/her neck swinging in backward motion towards the left hand grip part of the wheelchair frame.

Resident #001's care plan/ kardex in place at the time of the incident, was provided to Inspector #547 by the home's Program Manager for Resident Care (PMRC). The care plan identified the following information regarding the resident's transfer needs:

Under "transfer", the care plan states, two person pivot transfer or standing lift to change continence product.

Under "dressing", the care plan states, total care is required.

The PMRC provided Inspector #547 with a copy of the home's policy and procedure for Lifting and Transferring program #350.05 last revised August 2017. This procedure guideline specifically stated the following with regards to resident #001's pivot transfer:

3.lower the bed until the resident's feet rest on the floor.
4.Apply transfer belt
7.Assist resident to the side of the bed, close to the edge
8.Place resident's feet flat on the floor.
10.Assist resident to a standing position, allow the resident to get his or her balance and then pivot
11.On command "1-2-3 sit"; softly lower the resident into the wheelchair as the PSW bends their knees

PSW #116 indicated to Inspector #547 that resident #001's transfer from bed to wheelchair was not completed as per the home's expectations, as the resident did not weight bear, and they had to pull the resident's pants up and drag the resident to his/her wheelchair.

The Administrator stated that this transfer was not completed as per the home's policy

and procedure for safe transfers, and placed the resident was at risk for injury and discomfort.

The resident's SDM also provided evidence about concerns about resident #001's personal care provided in the afternoon of the same specified date.

On November 10, 2017 Inspector #547 reviewed the evidence that was provided to the Administrator. PSWs #101, #113 and #116 repositioned resident #001 in a wheelchair in order to apply a specified lift device transfer sling. The resident pushed away the sling and resisted care. PSW #101 pulled on resident #001’s head in a forward motion and then pull on the resident’s neck forcefully in a forward motion in order for PSW #113 and PSW #116 to apply the transfer sling behind the resident. Once the transfer sling was positioned behind the resident, all three PSW's pulled the sling attachment hooks forcefully in a forward motion to try to apply them to the specified transfer lift. The resident was pushing away from the lift device and kicking the base of the lift with his/her feet.

PSW #101 and PSW #116 indicated to Inspector #547 during interviews that resident #001's specified transfer and continence product change that specified afternoon was difficult. PSW #116 indicated that she had never provided afternoon care to resident #001, as she was new to the home, but that this transfer felt rough. PSW #101 indicated to Inspector #547 that she did not recall pulling on the resident’s head or neck for repositioning, but if that is the information that was provided, then she would not dispute it. PSW #101 indicated that providing resident #001 personal care can be difficult. On the specified afternoon, PSW #101 indicated there were too many staff members in the room to assist with the resident's care, which made the resident more aggressive.

The evidence provided by the resident's SDM identified unsafe transfer and repositioning techniques used when nursing staff were assisting resident #001 with personal care, placing resident #001 at risk for injury and discomfort. [s. 36.]

Issued on this 29th 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) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2017_621547_0016
Log No. / No de registre :	020148-17, 023639-17, 024254-17, 025569-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 28, 2017
Licensee / Titulaire de permis :	CITY OF OTTAWA Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL CHAMPLAIN 275 PERRIER STREET, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

To CITY OF OTTAWA, 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall ensure that resident #001 is protected from abuse and neglect.

Specifically, the Licensee is ordered to:

1. Review and revise resident #001's plan of care to identify clear and effective care interventions and approaches to be implemented by nursing staff when the resident is exhibiting responsive behaviours during the provision of care;

2. Communicate the content of resident #001's plan of care to all staff who provide care to the resident;

3. Ensure that registered nursing staff working on all shifts, closely monitor the effectiveness of all care interventions and approaches implemented by staff providing care to resident #001, with particular attention paid to needs associated with responsive behaviours, hearing/communication, repositioning/transfers and continence care;

4. Take immediate action if and when the implemented care interventions and approaches are not effective in managing resident #001's responsive behaviours. Reassess resident #001's needs on an on-going basis, explore alternative care interventions, including non-pharmaceutical approaches until the behaviours are successfully managed and the resident's needs are met; and

5. Document all key steps of the nursing process followed when caring for resident #001, making sure that the resident's Substitute Decision Maker is given an opportunity to participate fully in the development and the implementation of the resident's plan of care.

Grounds / Motifs :

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

Neglect is defined as per O.Reg. 79/10 s. 5. as:

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

Log #020148-17

This inspection is related to written complaint given to the home on a specified date by the Substitute Decision Maker (SDM) for resident #001. This complaint documented concerns regarding continence care and infection prevention related to the delayed treatment for a urinary tract infection for the resident. This complaint also documented concerns related to personal care and services provided to the resident by nursing staff in the home.

Resident #001 was admitted to the home on a specified date with several medical diagnoses including a specified cognitive impairment, anxiety and a joint disease to multiple areas.

On October 5, 2017 Inspector #547 reviewed resident #001's health care records and observed the following documentation in the resident current plan of care:

- Resident #001 has had responsive behaviours since admission to the home, in that the resident resists personal care and hygiene with physical and verbal aggression, requiring two staff or more, to assist with all personal care. This includes transfers, repositioning, mobility and toileting,
- Resident #001 requires hygiene care to be provided with one to two person assistance, depending on the resident's responsive behaviours,
- Resident #001 is hard of hearing to his/her left ear and needs to be spoken to softly in the opposite ear in short simple phrases,
- Resident #001 was admitted as being incontinent for bowel and bladder, requiring briefs to be applied at all times and changed as required by two or more staff members,
- Resident #001 was also identified on the home's initial skin assessment as high risk for impaired skin integrity issues related to impaired mobility, dementia and incontinence.

The resident's care plan utilized in the month of September 2017, indicated over 42 interventions identified by registered nursing staff, geriatric psychiatry consultations, and the resident's SDM to assist in management of the resident's responsive behaviours. Despite these interventions in place, behaviours were documented in the resident' progress notes, resident care flow sheets and the unit's 24 hour report book almost daily as not manageable or personal care was

refused. Resident #001's hearing and communication plan of care identified that the resident's decreased hearing ability combined with resident's short and long term memory loss and marked decrease in decision making abilities, impacted the resident's resistance to personal care.

Resident #001's physician orders documented an order on a specified date, to obtain a urine specimen for suspicion of urinary tract infection. No urine specimen was taken from the resident. Three days later, nursing staff discovered that this urine specimen was not collected. The urine specimen was collected however it had to wait another two days to be sent to the lab due to a holiday weekend. The urine specimen results returned to the home two days after this,with positive results for urinary tract infection. The physician was made aware of the positive test results the next day however the physician decided not to treat the resident based on the fact the resident was reported to be asymptomatic for infection. The home was not able to locate any documentation to indicate that the resident's SDM was made aware of these urine test results or the physician's assessment not to treat.

Inspector #547 reviewed the resident's SDM's written complaint, that identified a specified date, the resident's SDM arrived to the home after lunch to find the resident in bed. A foul odour of urine was noted in the resident's bedroom. The resident was in bed shivering, indicated to the SDM that he/she was cold and had pain in the legs. The resident's SDM asked the registered nursing staff to assess the resident. The registered nursing staff recalled the resident had positive urine specimen results and called the physician. An order for antibiotics was made, 15 days after the initial suspicion of a urinary tract infection was noted for the resident. The registered nursing staff returned to the resident's room and noted the foul odour of urine in the resident's room. The registered nursing staff located the smell to come from the resident's wheelchair cushion. Upon lifting the resident's wheelchair cushion, it was observed to be saturated and leaking yellow fluid that the registered nursing staff indicated to the SDM to be urine.

The home's investigation to this written complaint revealed that the resident's extra absorbent brief was still dry in the morning of this specified incident. The nursing staff were not required to change the resident's brief. The nursing staff returned the resident to bed after lunch with the resident's brief and clothing saturated with urine. Staff indicated to the registered nursing staff they did not notice any foul odour of urine after nursing care was provided to the resident and

the resident's wheelchair seat cushion was not verified.

On October 6, 2017 upon arrival to the resident's nursing unit, PSW #101 and #102 indicated to Inspector #547 before the end of their shift, that the resident had his/her brief changed that morning but had refused to have his/her brief changed after lunch as required. PSW #101 and #102 were reporting this to RN #100. RN #100 indicated to Inspector #547 and the PSW's that she would report this to the evening shift nursing staff. PSW #101 and #102 indicated that this is a regular behaviour for this resident as the resident often refuses personal care related to changing of a brief. PSW #103 indicated that the resident refuses to have his/her brief changed often, so when they do finally change the resident's brief, the resident's clothing and seat cushion are frequently completely saturated in urine.

On October 11, 2017 RN #100 indicated that resident #001's brief change pattern was to have his/her brief changed before getting up in the morning. The resident wears a super absorbent brief at night, that is applied in the evening. The resident's brief is not changed at all during the night in order to not disturb the resident's sleep pattern. Once the resident is up in his/her wheelchair, nursing staff monitor the resident for any incontinence signs otherwise the resident's brief is changed a second time after lunch. The resident no longer is toileted and is transferred to bed for the brief to be changed. The resident is then positioned back in his/her chair and the evening staff verify his/her brief to see if it requires to be changed before supper. The resident's brief is then changed at bedtime at a specified time for the night. RN #100 indicated that the resident is at high risk for impaired skin integrity, however resists care regularly and is often saturated in urine related to refusing to be changed. RN #100 further indicated that the resident's behaviour related to changing of the continence care products likely contributed to this infection, as the resident is often seated for many hours in his/her wheelchair with a soiled brief, which might contribute to the resident being at risk for urinary tract infections.

As such, the resident's continence care and comfort were not managed until 15 days after the initial concern for urinary tract infection was assessed by the nursing staff in the home.

Log # 024254-17

This inspection is related to a written complaints by resident #001's SDM to the

home's Administrator on another specified date, regarding care and services provided to resident #001 on specified evening and night shifts. The SDM identified a concern for resident #001's lack of care and services provided to the resident regarding the nursing staff leaving the resident seated in his/her wheelchair until the middle of the night shift and then care was provided by a male staff member. The resident's plan of care specifically indicated the resident is to receive care by a female nursing staff member only. The SDM further identified a concern that on the following evening, the SDM had to call the registered nursing staff to intervene with the resident's care being provided as it was already a later specified time in the evening. The resident was not in bed and the SDM was concerned that the resident would remain in the wheelchair as the previous night.

Resident progress notes and continence care flow sheets were reviewed for the following instances where the resident was noted to refuse to have the continence products changed:

a) documentation indicated the resident received continence care on the evening shift at a specified time on a specified date. The resident did not have any documented care provided over the night shift as per care plan. The resident refused to have personal care all day and evening the next day. The resident did not have any documented care provided over night as per care plan and the continence flow sheet documented that the resident's brief was changed during the day shift and personal care was then provided. As per this documentation, the resident had not received personal care for a period of approximately 36 hours.

b) documentation indicated the resident's continence product was changed and personal care was provided during the evening shift on a specified date. The resident did not have any documented care provided over the night shift as per care plan. The resident refused to have his/her continence product changed all day or personal care provided. The resident stayed in bed until staff got the resident up in the evening for the supper meal, however refused to have the continence product changed or personal care provided. The resident refused to be returned to bed at a specified time in the evening as required. The progress notes for the night shift indicated that the resident had remained in his/her wheelchair all night as he/she refused to be transferred to bed. The resident was transferred to bed and personal care was documented in the flow sheets as provided. As per this documentation, the resident had not received personal

care for a period of approximately 35 hours.

c) documentation indicated that the resident refused to have his/her continence product changed or personal care provided during the day shift however staff were able to get the resident up for meals on a specified date. The resident refused to be transferred to bed by evening staff or to have the continence product changed. The resident remained dressed, unchanged in day clothes and soiled continence products for over 16 hours. The evening staff on the following date identified the resident now had reddened skin on the buttocks.

d) documentation indicated that the resident refused to have his/her continence product changed all evening and stayed in his/her wheelchair. Night shift documented the resident remained in his/her wheelchair until the middle of the night. Care was then provided after over 12 hours in soiled continence product. The resident then remained in bed all the next day and refused personal care until before the evening shift. As per this documentation, the resident had not received personal care for another period of approximately 12 hours. On a specified date following these incidents, resident #001 was documented to have reddened skin on the buttocks.

Log # 023639-17

This inspection is related to a verbal complaint by resident #001's SDM to the home's Administrator on a specified date, of an alleged staff to resident incident of neglect that occurred during the evening and night of a specified date. The home submitted a critical incident report of alleged neglect that occurred whereby resident #001 refused to go to bed at a specified time on an evening and was left in his/her wheelchair all night until after breakfast on the following day. The SDM identified concern for resident #001's lack of care and services in that staff did not provide the essential personal care needs for continence, hygiene, comfort or sleep and rest routines for the resident as required in the resident's plan of care.

On October 6, 11, 12 and 13, 2017, Inspector #547 reviewed resident #001's health care records. Documentation over a specified 11 day period identified the following:

- documentation indicated resident #001 had personal care provided and brief changed at a specified time at the beginning of the evening shift. The resident

refused to be transferred to bed that evening as documented in the progress notes. No documentation for the night shift was found in regards to the resident's responsive behaviours or the provision of care. The resident remained in his/her wheelchair during the night shift. The resident went to breakfast the next day and then was transferred to bed, approximately 17 hours after the last provision of personal care.

- documentation indicated a care conference with the resident's SDM was held to discuss behavioural approaches for personal care and to review the resident's sleep pattern and preferences. A decision and a plan were developed to ensure that the resident is to be up on day shift every morning at 0800 hours and returned to bed at night at 2000 hours. Strategies and plans were developed to ensure that staff perform personal care for continence care products with one staff member, as too many staff working in the resident's room makes the resident agitated and aggressive. Clarifications were added regarding nursing staff are to attempt to change the resident once, if the resident refuses, staff are to leave the resident and return after a few minutes and attempt a second time. If the resident refuses the second time, leave the resident and return after a few minutes to then provide the care required. Registered nursing staff are to call the resident SDM if the resident has physically aggressive behaviour when attempting to provide personal care. Strategies for the residents hearing difficulties and the intervention of no male staff to provide the resident personal care, were reinforced.

- the following day, the resident's progress notes documented that the resident refused personal care on the evening shift and refused supper meal. The progress notes from the night shift documented that the resident was transferred to bed at some point during this shift. The following day, the resident's progress notes documented that the resident refused to have his/her continence product changed after lunch. The resident was transferred to bed at a specified time, whereby the resident's continence product was changed after approximately 12 hours in the same brief.

-Five days later, the resident progress notes documented at the end of the evening shift that the resident refused evening medications and refused to have his/her brief changed. Behaviour mapping tool started for the resident's behaviours. Night shift documented that the resident refused to have his/her brief changed after two attempts even when the resident had had a bowel movement. The resident's continence product was not changed nor was

personal care provided to the resident for approximately 16 hours.

On October 11, 2017 Inspector #547 interviewed RN #100 who indicated that nursing staff are not able to provide the care the resident needed due to the resident's responsive behaviours. RN #100 further indicated that the issue of staff not transferring the resident to bed at night and leaving the resident in a wheelchair all night or almost all night in the last few weeks was not acceptable.

On October 13,2017 Inspector #547 interviewed PSW #101 who indicated that she was able to provide the resident care when she was working on her own most of the time. The PSW stated that she finds it neglectful to not provide the resident personal care as the resident needs it, but it was not for a lack of trying to provide it to the resident.

Inspector #547 interviewed PSW #101, #102, #103 and #104 who indicated that they thought that it was unacceptable that resident #001 was left overnight in a wheelchair. PSW #102 indicated that she works with the Behaviour Supports Ontario (BSO) team and that sometimes they have to be three staff members to assist in changing the resident now that they have to do the care no matter if the resident refuses. The resident often will spit and hit them during care, and staff are afraid to get hurt. PSW #102 further indicated that staff are afraid to hurt the resident as well, as now they are to do the care even if the resident refuses or becomes physically resistive to care. PSW #101 indicated that she was concerned with the resident's resistance to care, and would like to be shown alternative methods to provide care safely for both the resident and nursing staff versus forced care.

On October 13, 2017 Inspector #547 asked the PMRC and PMCC what they had done to manage the ongoing complaints from the SDM. The SDM had identified in several interdisciplinary meetings that were held since the beginning of 2017 regarding resident #001's responsive behaviours, hearing loss issues and personal care provision. The PMRC indicated that the physician did attempt to check the resident's ears on two separate occasions in 2017, but the resident refused, and was assessed by the external audiologist. The PMRC and PMCC further indicated that they had not re-evaluated if the care was being provided or assessed if staff were using the identified plan of care approaches with resident #001, as they assumed that registered nursing staff were doing this on the unit. The PMCC indicated that she had not given the PSW's on the resident's unit any education or direction on how to safely manage the resident's behaviours

but to do the best they can. The PMCC and PMRC indicated that they were not aware of any geriatric psychiatry reassessment with resident #001's responsive behaviours since a specified date, regarding provision of personal care.

As such, the resident's plan of care regarding sleep and rest patterns was not followed which mixed up the day and night routines for the resident. This issue with sleep and rest patterns then affected the necessary nourishment, hydration needs and provision of prescribed medications for the resident due to fatigue. The nursing staff failed to provide resident #001 personal care as well as continence care management. Resident #001 was left seated in an adaptive wheelchair for long periods of time, with no documented repositioning or continence care provided posing infection and skin integrity risks for this resident. (547)

2. The licensee has failed to ensure that resident #001 was protected from abuse by anyone and free from physical abuse by staff in the home.

Physical abuse is defined as per O.Reg, 79/10:
" s.2.(1) physical abuse means,

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

s.2. (2) specified for the purposes of clause a of the definition in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances."

On a specified date, resident #001's SDM provided the Administrator evidence regarding concern about care provided to resident #001 the day before. The evidence was reviewed by Inspector #547 on November 10, 2017.

-The evidence identified morning personal care was provided to resident #001 by PSW #113 and PSW #116. Washing, changing the resident's continence brief and dressing was completed in order to transfer the resident to his/her wheelchair for breakfast.

The resident's arms were noted to be pushing PSW #113 away during personal care, however PSW #113 proceeded to wash the resident and change the

resident's continence brief. PSW #116 remained at the resident's other side of the bed, assisting by holding the resident's arm from hitting PSW #113, dressing and changing the resident's continence brief. Both PSW's then proceeded to transfer the resident from lying to sitting and repositioned the resident inappropriately and with excessive force. The evidence demonstrated inappropriate transfer techniques provided by PSW #113 and PSW #116 by using excessive force when transferring resident #001 from his/her bed to wheelchair, that jeopardized the resident's safety from falls or injury as identified in this report in WN #3.

-The evidence further identified afternoon personal care on this same day, whereby three PSW's applied a specified lift transfer sling roughly on the resident and when applying the sling hooks to the lift device. The evidence further demonstrated rough physical care by the three PSW's in changing of the resident's top also identified in this report in WN #3.

PSW #116 indicated to Inspector #547 during an interview regarding this evidence, that she was not familiar with the resident's plan of care as she had never provided the resident personal care before. PSW #116 indicated that she was following PSW #113's lead, as she was familiar with the resident's care needs. PSW #116 indicated that the resident's transfer was difficult during the morning care, as the resident did not weight bear at all, and they had to pull the resident's pants up and drag the resident to his/her wheelchair to prevent the resident from falling to the floor. PSW #116 indicated that they dropped the resident into the wheelchair related to the resident's weight and their positioning during this transfer. PSW #116 indicated that she found the afternoon care that was provided by three PSW's was rough on the resident. PSW #116 did not report these incidents to any registered nursing staff.

PSW #101 indicated to Inspector #547 during an interview regarding the afternoon personal care on this specified date, that she would not have chosen this transfer method for the resident. PSW #101 indicated the resident does not like this lift and always becomes aggressive. PSW #101 indicated to be following PSW #113's lead in this transfer, as PSW #113 was the nursing staff assigned the resident for that day. PSW #101 indicated that this transfer method is identified in the plan of care, but it shouldn't as it is not effective for the resident. She would have transferred the resident to bed, and then changed the resident's continence product with 1 staff member, to not overwhelm the resident.

The resident's SDM indicated to Inspector #547 that the resident complained of pain to the left buttocks in the days after these incidents related to the rough care provided during transfers.

The Administrator indicated to Inspector #547 that three PSW's were placed on administrative leave after she reviewed the evidence provided by the resident's SDM. She indicated that excessive force of pulling, dragging of the resident and the roughness in care was observed during the morning and afternoon care on this specified date and an investigation was immediately started. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 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 28th day of November, 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 : Lisa Kluke

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