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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 15, 2017	2017_505103_0009	004185-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE KINGSTON
309 QUEEN MARY ROAD KINGSTON ON K7M 6P4

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 1-3, 6-7, 2017

Log #004185-17 was inspected (alleged staff to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of this inspection, the inspector made resident observations, observed staff to resident interactions, reviewed the home's investigation notes related to the incidents of alleged staff to resident abuse, the home's abuse policy, the home's mandatory staff education related to abuse training and responsive behaviours and the home's attendance records for abuse training and responsive behaviours.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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 resident #001 and #002 were protected from incidents of staff to resident physical abuse.

According to O. Reg 79/10, s. 2 (1), physical abuse is defined as:
(a) The use of force by anyone other than a resident that causes physical injury or pain,
(b) Administering or withholding a drug for an inappropriate purpose, or
(c) The use of physical force by a resident that causes physical injury to another resident.

The Ministry of Health and Long Term Care home emergency pager received a call from the home on an identified date and time to report two incidents of staff to resident abuse involving resident #001 and resident #002.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. On an identified date, PSWs #110 and #111 were preparing the resident for bed. PSW #111 was interviewed and stated the resident was tense and resistive while PSW #110 attempted to provide care and responded in an identified rough manner with the resident. PSW #111 stated she believed the resident had been injured by PSW #110's actions.
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Upon completion of the care to resident #001, PSW #110 requested PSW #111 assist in providing care to resident #003. PSW #111 indicated there were no untoward incidents involving resident #003. PSW #111 then stated she entered resident #002's room. Resident #002's health care record was reviewed and indicated the resident was admitted on an identified date and had identified diagnoses.

PSW #111 stated she found resident #004 (resident #002's room-mate) was crying. The PSW indicated she sat on the bed and tried to console the resident. It was at that time, the PSW stated she heard PSW #110 say "don't you hit me" from behind the closed privacy curtain. PSW #111 stated she got up and when she went around the curtain, she observed PSW #110 holding resident #002 in an identified manner. The resident responded by attempting to reach out and strike PSW #110 who then reacted in an identified manner. According to PSW #111, she intervened to assist the resident with the completion of the care and PSW #110 left the room. PSW #111 stated while finishing resident #002's care, she noted an injury to resident #002.

PSW #111 indicated she just wanted everything to stop, but felt intimidated and frightened of the co-worker. She indicated she wasn't sure what to do. Upon completion of resident #002's care, PSW #111 observed PSW #110 assisting another resident with bedtime nourishment by the nursing desk. She sought the advice of a co-worker PSW #116 on an adjacent unit and asked her what she should do if she witnessed a staff

member being abusive toward a resident. PSW #111 stated she and the co-worker then sought out PSW #114 who indicated the incident had to be immediately reported to the registered staff.

PSW #114 was interviewed and indicated she was approached at approximately 2000-2015 hour by PSWs #111 and #116 and asked "what do I do when somebody is seen hurting a resident". PSW #114 indicated she told them it had to be immediately reported to the registered staff and tried to reassure PSW #111 by telling her about whistleblower protection. Following the conversation, PSW #114 indicated the two PSWs stated they were going on a break as PSW #111 stated she would only speak to RPN #115 who was currently on a break. PSW #114 stated she became nervous that the incidents would not be immediately reported and approached RPN #115 as she was returning from her break at approximately 2030 hour. PSW #114 advised her PSW #111 needed to speak to her about an alleged abuse.

RPN #115 was interviewed and stated she returned to the unit following her break just before 2030 hour. She indicated she was immediately approached by PSW #114 who gave her the heads up that PSW #111 needed to speak with her about a possible resident abuse. The RPN indicated the PSW had stated PSW #111 on gone for a break. The RPN indicated she immediately started looking for the PSW in the break room, the conference room and outside in the parking lot as these were all of the usual areas where staff took their breaks. The RPN also stated that while looking for PSW #111, she reported to the RN #117 that she thought there may have been an incident of staff to resident abuse and that she was trying to obtain the details. RPN #115 stated she observed PSW #111 walking into the building around 2030 hour and the RPN stated she approached the PSW and indicated they needed to talk. She stated she found a room to speak privately with the PSW who she described as upset and tearful. RPN #115 indicated the PSW described the two incidents of physical abuse indicating the care had been provided to resident #001 on or about 1900-1915 hour and the care had been provided to resident #002 on or about 1950 hour. The RPN stated the PSW expressed fear that she would get into trouble for reporting the incidents and indicated she was afraid to return to the unit. The RPN stated that after speaking with PSW #111, she and the PSW both went to report to RN #117.

RN #117 was interviewed and recalled RPN #115 approached her on or about 2030 hour to report a possible staff to resident abuse. She stated at that time the RPN had been unable to locate the PSW to elicit the actual details. The RN indicated a short time later, the RPN and the PSW came to speak with her with the details of the two incidents of

alleged staff to resident abuse. The RN stated the RPN notified the DOC at that time and they received instructions to advise PSW #110 would need to leave the home. The RN indicated the RPN waited with PSW #110 at the exit door until the PSW left the home. The RN stated the police, the MOHLTC emergency pager and the SDM's were all notified at that time of the allegations and witness statements were obtained.

A time period of approximately 1.5 hours lapsed from the witnessed physical abuse of resident #001 and #002 by PSW #111 until they were reported to RPN #115.

As a result of PSW #110's action, both resident #001 and #002 received identified injuries.

The DOC was interviewed in regards to any previous disciplinary actions involving PSW #110. The DOC stated the PSW had received a prior verbal reprimand for a residents' concern related to care and was required to review resident rights and the abuse policy as a result of the complaint.

The licensee also failed to comply with:
1. LTCHA, 2007, s. 6 (7) for failure to provide care to resident #001 and #002 in accordance with the care set out in the plan. (refer to WN #2)
2. LTCHA, 2007, s. 20 (1) for failure to ensure the home's written policy to promote zero tolerance of abuse and neglect was complied with. (refer to WN #3)
3. O. Reg 79/10, s. 219 (1) for failure to provide retraining to all staff related to the home's policy to promote zero tolerance of abuse and neglect of residents. (refer to WN #4)

The application of factors to be taken in account under O. Reg 79/10, s. 299 (1) requires a compliance order because of the severity and scope of the issues.

The severity of the incidents was actual harm. Residents #001 and #002 received injuries as a result of the PSW's actions. Resident #002 received injuries as a result of PSW #111's delay in reporting the witnessed abuse.

The scope of the incidents was assessed as a pattern. Two out of the three residents that PSW #111 witnessed PSW #110 caring for resulted in injuries as a result of the staff member's physically abusive care and all residents in the home were at risk of harm.

The compliance history was reviewed and no similar areas of non-compliance were

found, however the scope and severity of the incidents outweigh the factor of the compliance history. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in resident #001's plan of care was provided as outlined in the plan.

As outlined in WN #1, PSWs #110 and #111 provided bedtime care to resident #001 on an identified date. PSW #111 was interviewed and indicated she was familiar with the care needs of resident #001. She stated resident #001 had a cognitive impairment, utilized a mechanical lift for transfer into bed, required the assistance of two staff for all care needs and could be resistive and physically aggressive at times with care.

During the provision of that care, resident #001 demonstrated resistance which was a known responsive behaviour for this resident. PSW #111 stated PSW #110 had not communicated her intentions to the resident prior to starting the care. PSW #111 further indicated resident #001 was known to "tense up" at times and that was an indicator that the resident did not want the care provided. The PSW stated re-approach was an effective intervention to avoid physical aggression.

Resident #001's plan of care was reviewed.

Under "Behaviour-Physical Aggression" the plan indicated:
-staff to use gentle persuasion approach when providing care to eliminate the possibility of physical aggression (speak calmly, maintain eye contact, explain all care before

initiation),
-staff will ensure resident is safe and re-attempt care 5-10 minutes later when exhibiting physical aggression; report physical aggression to Registered staff,
-staff will ensure they communicate all care being provided prior to initiating care; allow resident time to process the information.

PSW #110 failed to ensure care was provided to resident #001 in accordance with the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure the care set out in resident #002's plan of care was provided as outlined in the plan.

As outlined in WN #1, PSWs #110 and #111 provided bedtime care to resident #002 on an identified date.

PSW #111 was interviewed and indicated she was familiar with the care needs of resident #002. She stated resident #002 had a cognitive impairment, required the assistance of one staff for bedtime care and could be resistive and physically aggressive at times with care.

PSW #111 stated resident #002 generally responded well to a slow approach and that re-approach was an effective intervention when the resident demonstrated resistance with care. PSW #111 stated PSW #110 should have re-approached the resident when he/she became agitated. Several staff, both registered and non registered were interviewed in regards to the ways staff respond when a resident is resistant to care. All interviewed staff stated re-approach is the most effective intervention.

Resident #002's plan of care was reviewed and indicated the following:

Under "Dressing"-
-history of aggression towards staff with dressing related to cognitive impairment,
-unpleasant mood during personal care identified, cover as much as possible during ADL's,
-extensive assistance of one staff with process of dressing/undressing,
Under "Personal Hygiene"-
-can be resistive to personal care; adjust routines/times according to resident's mood,
-if re-approach is ineffective, try another staff.
Under "Behavours"-

-occasionally refuses/resists care and can become physically/verbally aggressive,
-when behaviours occur, staff will provide for flexibility in ADL routine to accommodate resident mood.

The Administrator was interviewed in regards to this incident and indicated all staff have been trained to re-approach at the sign of any resistance to care.

PSW #110 failed to ensure care was provided to resident #002 in accordance with the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure care is provided to resident #001 and #002 as outlined in their plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the zero tolerance of abuse policy was complied with.

The home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", #RC-02-01-02, last updated in April 2016 was reviewed. Under "Reporting- All staff" it indicated:

-any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

PSW #111 failed to immediately report the alleged staff abuse involving resident #001. As a result, a second incident involving resident #002 resulted in injuries to this resident. Following the second witnessed incident of alleged physical abuse, PSW #111 further delayed the reporting of the incidents while she went on break and awaited the return of RPN #115. The PSW did not attempt to seek out the RN in charge of the building at that time. The total delay in reporting was an estimated 1.5 hours. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure all staff received annual retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents.

LTCHA, 2007, s. 76 (4) states, every licensee shall ensure that the persons who have received training under subsection (2), receive retraining in the areas mentioned in that subsection at intervals provided for in the regulation. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents is included in the list under subsection (2).

ADOC #112 was identified as the lead for staff education and was interviewed in regards to staff mandatory training including abuse training/education. She indicated the staff have a list of mandatory in-services, which include abuse training, which must be completed within the calendar year. She indicated the staff can either attend in-services in person or complete the training on-line.

ADOC #112 was able to demonstrate the abuse training offered by the home includes information related to mandatory reporting and whistleblowing protection. This inspector requested a copy of PSW #110's mandatory abuse training for 2015 and 2016. ADOC #112 indicated PSW #110 had completed abuse training last in December 2015, but had not completed the training for 2016. ADOC #112 stated an email was sent to all staff dated November 17, 2016 reminding them that all mandatory in-services are required to be completed before December 2016. Additionally, ADOC#112 stated another email was sent on January 10, 2017 to the Administrator and various department heads with a list of twenty-eight names of employees who had not yet completed the 2016 mandatory abuse training and asking for their assistance to have the staff complete the education. PSW #110 was included in this list.

The Administrator was interviewed and stated all employees are given the year to complete the mandatory training sessions. The Administrator indicated the home had identified a number of staff that did not complete the abuse training in 2016, but indicated there were no measures in place at that time to ensure staff did not work until such time the training was completed.

The home failed to ensure all staff received the mandatory abuse training in 2016. A total of twenty-eight staff did not complete the abuse training including PSW #110 responsible for two incidents of resident abuse. [s. 219. (1)]

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

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Issued on this 15th day of March, 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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2017_505103_0009
Log No. / Registre no:	004185-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 15, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE KINGSTON 309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tawnia Pilgrim

To EXTENDICARE (CANADA) INC., 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 is hereby ordered to develop a process:

-to emphasize the importance of immediate reporting by all staff in the event of any suspected, witnessed and alleged incidents of resident abuse,

-that addresses strategies that facilitate immediate reporting without fear of reprisal from co-workers,

-to ensure all staff complete the mandatory abuse training/education on an annual basis,

-that outlines the actions that will be taken by management when the annual mandatory abuse training/education is not completed annually, and the person (s) responsible to oversee it.

Grounds / Motifs :

1. The licensee has failed to ensure resident #001 and #002 were protected from incidents of staff to resident physical abuse.

According to O. Reg 79/10, s. 2 (1), physical abuse is defined as:
(a) The use of force by anyone other than a resident that causes physical injury or pain,
(b) Administering or withholding a drug for an inappropriate purpose, or
(c) The use of physical force by a resident that causes physical injury to another resident.

The Ministry of Health and Long Term Care home emergency pager received a

call from the home on an identified date and time to report two incidents of staff to resident abuse involving resident #001 and resident #002.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. On an identified date, PSWs #110 and #111 were preparing the resident for bed. PSW #111 was interviewed and stated the resident was tense and resistive while PSW #110 attempted to provide care and responded in an identified rough manner with the resident. PSW #111 stated she believed the resident had been injured by PSW #110's actions.
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Upon completion of the care to resident #001, PSW #110 requested PSW #111 assist in providing care to resident #003. PSW #111 indicated there were no untoward incidents involving resident #003. PSW #111 then stated she entered resident #002's room. Resident #002's health care record was reviewed and indicated the resident was admitted on an identified date and had identified diagnoses.

PSW #111 stated she found resident #004 (resident #002's room-mate) was crying. The PSW indicated she sat on the bed and tried to console the resident. It was at that time, the PSW stated she heard PSW #110 say "don't you hit me" from behind the closed privacy curtain. PSW #111 stated she got up and when she went around the curtain, she observed PSW #110 holding resident #002 in an identified manner. The resident responded by attempting to reach out and strike PSW #110 who then reacted in an identified manner. According to PSW #111, she intervened to assist the resident with the completion of the care and PSW #110 left the room. PSW #111 stated while finishing resident #002's care, she noted an injury to resident #002.

PSW #111 indicated she just wanted everything to stop, but felt intimidated and frightened of the co-worker. She indicated she wasn't sure what to do. Upon completion of resident #002's care, PSW #111 observed PSW #110 assisting another resident with bedtime nourishment by the nursing desk. She sought the advice of a co-worker PSW #116 on an adjacent unit and asked her what she should do if she witnessed a staff member being abusive toward a resident. PSW #111 stated she and the co-worker then sought out PSW #114 who indicated the incident had to be immediately reported to the registered staff.

PSW #114 was interviewed and indicated she was approached at approximately 2000-2015 hour by PSWs #111 and #116 and asked "what do I do when

somebody is seen hurting a resident". PSW #114 indicated she told them it had to be immediately reported to the registered staff and tried to reassure PSW #111 by telling her about whistleblower protection. Following the conversation, PSW #114 indicated the two PSWs stated they were going on a break as PSW #111 stated she would only speak to RPN #115 who was currently on a break. PSW #114 stated she became nervous that the incidents would not be immediately reported and approached RPN #115 as she was returning from her break at approximately 2030 hour. PSW #114 advised her PSW #111 needed to speak to her about an alleged abuse.

RPN #115 was interviewed and stated she returned to the unit following her break just before 2030 hour. She indicated she was immediately approached by PSW #114 who gave her the heads up that PSW #111 needed to speak with her about a possible resident abuse. The RPN indicated the PSW had stated PSW #111 on gone for a break. The RPN indicated she immediately started looking for the PSW in the break room, the conference room and outside in the parking lot as these were all of the usual areas where staff took their breaks. The RPN also stated that while looking for PSW #111, she reported to the RN #117 that she thought there may have been an incident of staff to resident abuse and that she was trying to obtain the details. RPN #115 stated she observed PSW #111 walking into the building around 2030 hour and the RPN stated she approached the PSW and indicated they needed to talk. She stated she found a room to speak privately with the PSW who she described as upset and tearful. RPN #115 indicated the PSW described the two incidents of physical abuse indicating the care had been provided to resident #001 on or about 1900-1915 hour and the care had been provided to resident #002 on or about 1950 hour. The RPN stated the PSW expressed fear that she would get into trouble for reporting the incidents and indicated she was afraid to return to the unit. The RPN stated that after speaking with PSW #111, she and the PSW both went to report to RN #117.

RN #117 was interviewed and recalled RPN #115 approached her on or about 2030 hour to report a possible staff to resident abuse. She stated at that time the RPN had been unable to locate the PSW to elicit the actual details. The RN indicated a short time later, the RPN and the PSW came to speak with her with the details of the two incidents of alleged staff to resident abuse. The RN stated the RPN notified the DOC at that time and they received instructions to advise PSW #110 would need to leave the home. The RN indicated the RPN waited with PSW #110 at the exit door until the PSW left the home. The RN stated the

police, the MOHLTC emergency pager and the SDM's were all notified at that time of the allegations and witness statements were obtained.

A time period of approximately 1.5 hours lapsed from the witnessed physical abuse of resident #001 and #002 by PSW #111 until they were reported to RPN #115.

As a result of PSW #110's action, both resident #001 and #002 received identified injuries.

The DOC was interviewed in regards to any previous disciplinary actions involving PSW #110. The DOC stated the PSW had received a prior verbal reprimand for a residents' concern related to care and was required to review resident rights and the abuse policy as a result of the complaint.

The licensee also failed to comply with:
1. LTCHA, 2007, s. 6 (7) for failure to provide care to resident #001 and #002 in accordance with the care set out in the plan. (refer to WN #2)
2. LTCHA, 2007, s. 20 (1) for failure to ensure the home's written policy to promote zero tolerance of abuse and neglect was complied with. (refer to WN #3)
3. O. Reg 79/10, s. 219 (1) for failure to provide retraining to all staff related to the home's policy to promote zero tolerance of abuse and neglect of residents. (refer to WN #4)

The application of factors to be taken in account under O. Reg 79/10, s. 299 (1) requires a compliance order because of the severity and scope of the issues.

The severity of the incidents was actual harm. Residents #001 and #002 received injuries as a result of the PSW's actions. Resident #002 received injuries as a result of PSW #111's delay in reporting the witnessed abuse.

The scope of the incidents was assessed as a pattern. Two out of the three residents that PSW #111 witnessed PSW #110 caring for resulted in injuries as a result of the staff member's physically abusive care and all residents in the home were at risk of harm.

The compliance history was reviewed and no similar areas of non-compliance were found, however the scope and severity of the incidents outweigh the factor

of the compliance history. [s. 19. (1)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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