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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 08, 2019	2019_722630_0003 (A1)	009778-18, 026476-18, 026477-18, 026478-18, 026479-18, 026480-18, 026484-18, 026485-18, 026486-18, 028482-18, 028717-18, 031415-18, 031633-18, 000644-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Port Stanley
4551 East Road PORT STANLEY ON N5L 1J6

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Administrator/Director of Care requested extensions to the compliance due dates for CO #001 and CO #002 to March 22, 2019, related to the training that must be provided to staff.

Issued on this 8 th day of February, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended 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): January 21, 22, 23 and 24, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:

Critical Incident Log #031415-18 / CI 2669-000017-18

Critical Incident Log #031633-18 / CI 2669-000018-18

Critical Incident Log #000644-19 / CI 2669-000001-19

Related to the falls prevention and management:

Critical Incident Log #009778-19 / CI 2669-000009-18

Critical Incident Log #028482-18 / CI 2669-000015-18

Critical Incident Log #028717-18 / CI 2669-000016-18

The following Follow-up intakes were completed within this inspection:

Follow-up Log #026476-18 for Compliance Order (CO) #001 from Resident Quality Inspection (RQI) #2018_725522_0002 related to the prevention of abuse and neglect.

Follow-up Log #026477-18 for CO #002 from RQI #2018_725522_0002 related to the written policy on the prevention of abuse and neglect.

Follow-up Log #026478-18 for CO #003 from RQI #2018_725522_0002 related to immediate investigation of alleged abuse or neglect.

Follow-up Log #026479-18 for CO #004 from RQI #2018_725522_0002 related to immediate reporting of alleged abuse or neglect to the Director.

Follow-up Log #026480-18 for CO #005 from RQI #2018_725522_0002 related to documentation of complaints.

Follow-up Log #026484-18 for CO #006 from RQI #2018_725522_0002 related to response to medication incidents and adverse drug reactions.

Follow-up Log #026485-18 for CO #007 from RQI #2018_725522_0002 related to staff training and orientation.

Follow-up Log #026486-18 for CO #008 from RQI #2018_725522_0002 related to annual evaluation of the training and orientation program.

During the course of the inspection, the inspector(s) spoke with the Resident Assessment Instrument (RAI) Coordinator, the Programs Manager, the Registered Dietitian (RD), the Clinical Consulting Pharmacist, the Office Manager, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RN), RPNs, Personal Support Workers (PSWs), the Physiotherapy Aide (PTA) and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes and reviewed written records of program evaluations and staff training.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Training and Orientation

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (2)	CO #005	2018_725522_0002	524
O.Reg 79/10 s. 135.	CO #006	2018_725522_0002	524
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_725522_0002	630
O.Reg 79/10 s. 216. (2)	CO #008	2018_725522_0002	689
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #003	2018_725522_0002	630
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #004	2018_725522_0002	630

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	Légende 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. 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 comply with compliance order #002 from inspection 2018_725522_0002 served on September 18, 2018, with a compliance date of October 31, 2018.

The licensee was ordered to ensure that they were compliant with s. 20 (1) of the

LTCHA.

Specifically the licensee was ordered to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee has failed to comply with the written policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 last updated April 2017. This policy stated:
- "In cases of physical and/or sexual abuse it is imperative to preserve potential evidence as the incident may result in criminal charges and ensure that: accurate detailed descriptions of injuries/condition are documented in the resident chart"
- "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 the time."
- "The person reporting the suspected abuse will follow the home's reporting/provincial requirements to ensure the information is provided to the home Administrator/designate immediately."
- "All staff, volunteers, contractors and affiliated personnel are required to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect."

The definition of physical abuse in Section 2(1) of the Ontario Regulation 79/10 includes "the use of physical force by a resident that causes physical injury to another resident."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an alleged incident of resident to resident abuse that took place on a specific date. There was a four day difference between the date of the incident and the date it was reported to the MOHLTC. This report indicated that the MOHLTC after-hours number was not used by staff for this incident. The report also described a specific injury incurred by one of the residents.

During an interview with an identified staff member they said that when there was an altercation between two residents the staff were expected to separate the two residents, start a risk management report and report it to the management in the home. Another staff member said if there was an altercation between two residents they would be expected to do a head to toe assessment if there was

any suspected injury.

The clinical record for the identified resident did not include a clear description of the injuries and did not include a head to toe assessment.

During an interview the Resident Assessment Instrument Coordinator (RAI-C) told Inspector #630 that they were involved in reporting this incident to the MOHLTC. They said they had read about the incident in shift report and prior to noticing this the staff had not reported the incident to the management in the home or the MOHLTC. The RAI-C said that there was no head to toe assessment done by staff for the resident but the progress notes included an entry that there were signs of an injury. The RAI Coordinator and Inspector #630 reviewed the progress notes and assessment for this resident and the RAI-C acknowledged that there was no further assessments or documentation regarding the injuries sustained. The RAI-C said it was the expectation that staff would follow the home's policy on prevention of abuse and neglect which included notifying the management of the home immediately of any include of alleged abuse who would then initiate the CIS report to the MOHLTC. The RAI-C also said it was the expectation within this policy that staff would complete and document a full assessment for injuries after an alleged incident of resident to resident.

The licensee has failed to comply with compliance order #002 from inspection 2018_725522_0002. Based on these interview and record reviews the written policy that promotes zero tolerance of abuse and neglect of residents was not complied with relating to an incident of alleged resident to resident abuse (630). [s. 20. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order #007 from Resident Quality Inspection (RQI) #2018_725522_2018 served on September 18, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that:
a) No staff performs their responsibilities before receiving training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities;
b) No staff performs their responsibilities before receiving training in the areas mentioned below:
i. The Residents' Bill of Rights.
ii. The long-term care home's mission statement.
iii. The long-term care home's policy to promote zero tolerance of abuse neglect of residents.
iv. The duty under section 24 to make mandatory reports.
v. The protections afforded by section 26.
vi. The long-term care home's policy to minimize the restraining of residents.
vii. Fire prevention and safety.
viii. Emergency and evacuation procedures.
ix. Infection prevention and control.
c) All staff receive training annually relating to the following:
i. The Residents' Bill of Rights;
ii. The home's policy to promote zero tolerance of abuse and neglect of residents;
iii. The duty to make mandatory reports under section 24;
iv. The whistle-blowing protections.
d) All staff who provide direct care to residents receive annual training in abuse recognition and prevention.
e) All staff who provide direct care to residents receive annual training in falls prevention and management.

The licensee completed steps a), d) and e).

The licensee failed to complete steps b) and c) related to staff not receiving training prior to performing their responsibilities and that all staff had not received retraining annually.

The definition of "staff" in the Long-Term Care Homes Act, 2007 includes "persons who work at the home, pursuant to a contract or agreement with the licensee."

The home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of staff to resident abuse which involved a staff member who was working in the home pursuant to a contract.

Inspector #689 reviewed the home's training records for mandatory education provided by the home at the time of the follow up inspection. The "Employee Knowledge Program Summary" for the period of January 1, 2018, to December 31, 2018, was reviewed and did not show education completed by any staff who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The home's policy titled Mandatory Education for Staff, Students and Volunteers, RC-01-01-02, last updated January 2018, was reviewed and stated the following:
-"Staff means individuals who work in the home, including employees, external contractors, agency staff and others who work in the home pursuant to a contract or agreement with the home."
-"Ensure staff who are at the home pursuant to a contact or agreement receive the following information before providing services:
a. Residents' Bill of Rights and/or Commitment to Residents;
b. The home's policy to promote zero tolerance of abuse and neglect of residents;
c. The duty to make mandatory reports;
d. Whistle-blowing protections;
e. Fire prevention and safety;
f. Emergency and evacuation procedures; and
g. Infection prevention and control:
i) Hand hygiene;
ii) Modes of infection transmission;
iii) Cleaning and disinfection practices;

iv) Use of personal protective equipment."

During an interview the Resident Assessment Instrument-Coordinator (RAI-C) stated that home had contracted employees that worked in the home including the Registered Dietitian (RD), the Physiotherapist (PT), the Physiotherapy Assistant (PTA), and a foot care nurse. The RAI-C reviewed the home's policy titled Mandatory Education for Staff, Students and Volunteers, RC-01-01-02, and read the definition of "staff". RAI-C confirmed that the PT, PTA, RD, foot care services, nursing agency staff and any other employee pursuant to a contract or agreement would fall under the home's definition of "staff" according to the home's policy. When asked what the home's process was with regards to training of persons who worked in the home pursuant to a contract or agreement with an employment agency or other third party, the RAI-C stated that there was no process that they were aware of and thought it would be the responsibility from their agencies to provide training. When asked by the inspector if these staff members had received the mandatory education related to the residents' bill of rights, the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports, whistle blowing protections, fire prevention and safety, and infection prevention and control, the RAI-C stated they were confident that they had not.

No training records or documented evidence was provided to the inspector which showed that the required mandatory training had been completed prior to the employee start date, or that annual training was completed by the staff listed above.

During an interview with an identified staff member they stated that they worked in the home through a contract. They stated that there was training provided by Extendicare to staff, but they had not completed the official training like the home did with the personal support workers or the registered nursing staff. The staff member stated that they were not provided training during orientation when they first started at the home and did not complete online mandatory training. The staff member confirmed that they had not received any formal training throughout their years of work from the management at the home.

During an interview with another staff member they stated that they worked in the home through a contract. The staff member stated that the home did not provide them with mandatory online training. When asked if they had received annual training from the home related to the residents' bill of rights, the homes policy to

promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports, and whistle-blowing protections, they stated that they had not.

The licensee has failed to comply with compliance order #007 from inspection #2018_725522_2018. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned above, and that all staff had received retraining annually relating to the following: the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections (689). [s. 76.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The report stated that concerns had been brought forward regarding the care provided to a specific resident by an identified staff member. The report stated that one of the actions planned to correct this situation and prevent recurrence was revisions for the plan of care for the resident related to staff approach for their behaviours.

During an interview with an identified staff members they reported that this resident had a history of specific types of responsive behaviours. They said that concerns had been brought forward to them regarding the approach used by a specific staff member with this resident.

During an interview with another staff member they said that this resident had specific types of responsive behaviours and thought there were specific triggers. The staff member said they were not familiar with the interventions that were in place for this resident at the time. They said they had received a letter of discipline related to the incident and were required to complete re-education.

During an interview with the Behavioural Supports Ontario Registered Practical Nurse (BSO RPN) they said this resident had not yet been assessed by the BSO team and had not been part of the BSO program in the home. When asked what the process was for assessing residents with changes in behaviours or increased behaviours, the BSO said they would identify increased behaviours through reading the progress notes and reviewing the staff documentation. BSO RPN said they would then sit and talk about the behaviours and what could be done to decrease or address the behaviours but tended not to document those discussions. BSO RPN said that they tracked behaviours monthly on a statistics sheet in terms of the types of behaviours and when they were occurring, but did not summarize these in a progress notes or assessment forms for the residents. BSO RPN said this resident had specific types of behaviours and there were certain triggers and there certain interventions in place. BSO RPN said that staff were expected to look in the plan of care to know about behaviours and interventions.

The clinical record for this resident showed that there had been multiple incident of responsive behaviours between their admission and the date of the CIS report. The clinical record did not include assessments or reassessments of the behaviours. The plan of care for the resident showed that the resident had behaviours but the plan of care did not include all the triggers or interventions that had been identified by staff during interviews or in the resident's progress notes.

During an interview the Resident Assessment Instrument Coordinator (RAI-C) they said that they were familiar with the incident and this resident. The RAI-C said that this resident had specific behaviours which required a specific type of approach from staff and that the type of approach taken during this incident would not have been the type of approach needed by this resident.

Based on these interviews and record reviews this identified resident was demonstrating frequent responsive behaviours between their admission to the home on and the Critical Incident. During the interviews various triggers for these behaviours were described and were not consistent with the triggers identified in the plan of care. The strategies that were developed to respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented assessments or reassessments. In addition, the actions taken specifically by a staff member as reported in the CIS report did not meet the needs of the resident

related to responsive behaviours.

B) The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

The home submitted a Critical Incident System (CIS) report to the MOHLTC regarding an alleged incident of staff to resident abuse. The report stated that the resident had a history of responsive behaviours and at the time of the incident the resident was having a specific type of behaviour.

During an interview the BSO RPN said they were familiar with this resident and the resident had specific types of behaviours. The BSO RPN said that as the BSO team in the home they looked at the behaviours charted each week and then they would sit down and talk about what things might work but they did not really document these discussions. The BSO RPN said they tracked the type and frequency of behaviours each month but this did not include the triggers or interventions or document an assessment of the trends or patterns identified.

During interviews with staff members they reported that this identified resident had a history of specific types of responsive behaviours. The staff members reported there were specific types of interventions that the resident required. They said that they had witnessed the incident between this identified staff member and the resident and that at the time the resident was showing specific responsive behaviours. The staff reported that the actions taken by this staff member did not meet the needs of the resident at the time regarding the behaviours.

The home's investigation documentation included a written statement by the staff member involved in the incident. This statement described the events leading up to the incident and the incident itself and described specific responsive behaviours that the resident was having at the time. The staff member reported that at the time they had taken specific actions related to the resident's behaviours.

The clinical record for this resident showed that there had been multiple incidents of responsive behaviours. The clinical record did not include reassessments of

the behaviours. The plan of care for the resident showed that the resident had behaviours but the plan of care did not include all the triggers or interventions.

During an interview the RAI-C said they were familiar with this resident and that the staff in the home were monitoring their behaviours as they were starting to increase during a specific time frame. RAI-C said that at the time of the incident there had been a specific trigger for the resident's responsive behaviours and that the staff member had responded in a specific way which did not seem to meet the needs of the resident at the time. The RAI-C said that this staff member would have had access to the plan of care in PCC and the progress notes to know about this resident's behaviours and the interventions prior to the incident.

Based on these interviews and record reviews this resident was demonstrating frequent responsive behaviours prior to the Critical Incident. During the interviews various triggers for these behaviours were described, however these were not consistent with the triggers identified in the plan of care. The strategies that were developed to respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented reassessments. In addition, the actions taken specifically by this staff member as reported in the CIS report did not meet the needs of the resident related to responsive behaviours (630). [s. 53. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 8 th day of February, 2019 (A1)

[redacted]

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A1)
Inspection No. / No de l'inspection :	2019_722630_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009778-18, 026476-18, 026477-18, 026478-18, 026479-18, 026480-18, 026484-18, 026485-18, 026486-18, 028482-18, 028717-18, 031415-18, 031633-18, 000644-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 08, 2019(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Port Stanley 4551 East Road, PORT STANLEY, ON, N5L-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynsey McIntyre

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_725522_0002, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s 20 (1) of the LTCHA.

Specifically the licensee shall ensure the following:

a) All staff comply with the home's written policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 to ensure "accurate detailed descriptions of injuries/condition are documented in the residents chart" related to any alleged resident to resident abuse.

b) All staff comply with the home's written policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 to ensure any alleged resident to resident abuse is immediately reported to the appropriate supervisor in the home on duty (or on call) at the time of the witnessed or alleged incident of abuse or neglect.

c) The home's Administrator/Director of Care (DOC) will review the home's written policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 in-person with all Registered Practical Nurses (RPNs) and Registered Nurses (RNs) working in the home . The home must maintain a documented record of this training which includes the date and the signatures of the participants.

d) The home's Administrator/Director of Care (DOC) will ensure all staff working in the home review the August 31, 2018, memorandum to Long-Term Care Home Administrators from the Director, Long-Term Care Inspections Branch titled "Clarification of Mandatory and Critical Incident Reporting Requirements" which is posted on the ltchomes.net website. The home's Administrator/Director of Care (DOC) will ensure a copy of this memorandum is available to the staff working in the home at all times. The home must maintain a documented record of this training which includes the date and the signatures of the participants.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection 2018_725522_0002 served on September 18, 2018, with a compliance date of October 31, 2018.

The licensee was ordered to ensure that they were compliant with s. 20 (1) of the LTCHA.

Specifically the licensee was ordered to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee has failed to comply with the written policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 last updated April 2017. This policy stated:
- "In cases of physical and/or sexual abuse it is imperative to preserve potential evidence as the incident may result in criminal charges and ensure that: accurate detailed descriptions of injuries/condition are documented in the resident chart"
- "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 the time."
- "The person reporting the suspected abuse will follow the home's reporting/provincial requirements to ensure the information is provided to the home Administrator/designate immediately."
- "All staff, volunteers, contractors and affiliated personnel are required to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect."

The definition of physical abuse in Section 2(1) of the Ontario Regulation 79/10 includes "the use of physical force by a resident that causes physical injury to another resident."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an alleged incident of resident to resident abuse that took place on a specific date. There was a four day difference between the date of the incident and the date it was reported to the MOHLTC. This report indicated that the MOHLTC after-hours number was not used by staff for this incident. The report also described a specific injury incurred by one of the residents.

During an interview with an identified staff member they said that when there was an altercation between two residents the staff were expected to separate the two

residents, start a risk management report and report it to the management in the home. Another staff member said if there was an altercation between two residents they would be expected to do a head to toe assessment if there was any suspected injury.

The clinical record for the identified resident did not include a clear description of the injuries and did not include a head to toe assessment.

During an interview the Resident Assessment Instrument Coordinator (RAI-C) told Inspector #630 that they were involved in reporting this incident to the MOHLTC. They said they had read about the incident in shift report and prior to noticing this the staff had not reported the incident to the management in the home or the MOHLTC. The RAI-C said that there was no head to toe assessment done by staff for the resident but the progress notes included an entry that there were signs of an injury. The RAI Coordinator and Inspector #630 reviewed the progress notes and assessment for this resident and the RAI-C acknowledged that there was no further assessments or documentation regarding the injuries sustained. The RAI-C said it was the expectation that staff would follow the home's policy on prevention of abuse and neglect which included notifying the management of the home immediately of any include of alleged abuse who would then initiate the CIS report to the MOHLTC. The RAI-C also said it was the expectation within this policy that staff would complete and document a full assessment for injuries after an alleged incident of resident to resident.

The licensee has failed to comply with compliance order #002 from inspection 2018_725522_0002. Based on these interview and record reviews the written policy that promotes zero tolerance of abuse and neglect of residents was not complied with relating to an incident of alleged resident to resident abuse. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 1 as it was related to 1 out of 3 incidents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued September 28, 2018 (2018_725522_0002). (630)

Mar 22, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_725522_0002, CO #007;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The home must be compliant with s. 76 of the LTCHA.

Specifically the licensee shall ensure the following:

a) The home's policy titled "Mandatory Education for, Staff, Students and Volunteers" RC-01-01-02 is complied with for all staff who work at the home, including staff working in the home pursuant to a contract or agreement with the licensee.

b) The Administrator/Director of Care (DOC) will assess and document the training that has been provided to the staff working in the home pursuant to a contract or agreement and then ensure any gaps in the required training, as identified in this policy and s. 76 of the LTCHA, is provided. The home must keep a documented record of the training provided which includes the date and the signatures of the participants.

c) All physiotherapists (PTs), physiotherapist aides (PTAs) and all other staff who provide direct care to residents and work in the home pursuant to a contract or agreement with the licensee, receive training on mental health issues, including caring for persons with dementia and behaviour management. This must include training on techniques and approaches related to responsive behaviours in accordance with Ontario Regulation 79/10 s. 221 (3). The home must keep a documented record of the training provided which includes the date and the signatures of the participants.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #007 from Resident Quality Inspection (RQI) #2018_725522_2018 served on September 18, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that:
a) No staff performs their responsibilities before receiving training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities;
b) No staff performs their responsibilities before receiving training in the areas mentioned below:
i. The Residents' Bill of Rights.
ii. The long-term care home's mission statement.
iii. The long-term care home's policy to promote zero tolerance of abuse neglect of residents.
iv. The duty under section 24 to make mandatory reports.
v. The protections afforded by section 26.
vi. The long-term care home's policy to minimize the restraining of residents.
vii. Fire prevention and safety.
viii. Emergency and evacuation procedures.
ix. Infection prevention and control.
c) All staff receive training annually relating to the following:
i. The Residents' Bill of Rights;
ii. The home's policy to promote zero tolerance of abuse and neglect of residents;
iii. The duty to make mandatory reports under section 24;
iv. The whistle-blowing protections.
d) All staff who provide direct care to residents receive annual training in abuse recognition and prevention.
e) All staff who provide direct care to residents receive annual training in falls prevention and management.

The licensee completed steps a), d) and e).

The licensee failed to complete steps b) and c) related to staff not receiving training prior to performing their responsibilities and that all staff had not received retraining annually.

The definition of "staff" in the Long-Term Care Homes Act, 2007 includes “persons who work at the home, pursuant to a contract or agreement with the licensee.”

The home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of staff to resident abuse which involved a staff member who was working in the home pursuant to a contract.

Inspector #689 reviewed the home’s training records for mandatory education provided by the home at the time of the follow up inspection. The “Employee Knowledge Program Summary” for the period of January 1, 2018, to December 31, 2018, was reviewed and did not show education completed by any staff who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The home’s policy titled Mandatory Education for Staff, Students and Volunteers, RC-01-01-02, last updated January 2018, was reviewed and stated the following:
-“Staff means individuals who work in the home, including employees, external contractors, agency staff and others who work in the home pursuant to a contract or agreement with the home.”
-“Ensure staff who are at the home pursuant to a contact or agreement receive the following information before providing services:
a. Residents’ Bill of Rights and/or Commitment to Residents;
b. The home’s policy to promote zero tolerance of abuse and neglect of residents;
c. The duty to make mandatory reports;
d. Whistle-blowing protections;
e. Fire prevention and safety;
f. Emergency and evacuation procedures; and
g. Infection prevention and control:
i) Hand hygiene;
ii) Modes of infection transmission;
iii) Cleaning and disinfection practices;
iv) Use of personal protective equipment.”

During an interview the Resident Assessment Instrument-Coordinator (RAI-C) stated that home had contracted employees that worked in the home including the Registered Dietitian (RD), the Physiotherapist (PT), the Physiotherapy Assistant (PTA), and a foot care nurse. The RAI-C reviewed the home’s policy titled Mandatory

Education for Staff, Students and Volunteers, RC-01-01-02, and read the definition of "staff". RAI-C confirmed that the PT, PTA, RD, foot care services, nursing agency staff and any other employee pursuant to a contract or agreement would fall under the home's definition of "staff" according to the home's policy. When asked what the home's process was with regards to training of persons who worked in the home pursuant to a contract or agreement with an employment agency or other third party, the RAI-C stated that there was no process that they were aware of and thought it would be the responsibility from their agencies to provide training. When asked by the inspector if these staff members had received the mandatory education related to the residents' bill of rights, the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports, whistle blowing protections, fire prevention and safety, and infection prevention and control, the RAI-C stated they were confident that they had not.

No training records or documented evidence was provided to the inspector which showed that the required mandatory training had been completed prior to the employee start date, or that annual training was completed by the staff listed above.

During an interview with an identified staff member they stated that they worked in the home through a contract. They stated that there was training provided by Extendicare to staff, but they had not completed the official training like the home did with the personal support workers or the registered nursing staff. The staff member stated that they were not provided training during orientation when they first started at the home and did not complete online mandatory training. The staff member confirmed that they had not received any formal training throughout their years of work from the management at the home.

During an interview with another staff member they stated that they worked in the home through a contract. The staff member stated that the home did not provide them with mandatory online training. When asked if they had received annual training from the home related to the residents' bill of rights, the homes policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports, and whistle-blowing protections, they stated that they had not.

The licensee has failed to comply with compliance order #007 from inspection #2018_725522_2018. The licensee has failed to ensure that no staff performed their

responsibilities before receiving training in the areas mentioned above, and that all staff had received retraining annually relating to the following: the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections. [s. 76.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 1 as it was related to a specific sub-section of the staff. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued September 28, 2018 (2018_725522_0002). (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10 s. 53 (4).

Specifically the licensee must ensure the following:

The home's policy titled "Responsive Behaviours" RC-17-01-04 is complied with for resident #003 and any other resident displaying responsive behaviours. This includes, but is not limited to:
a) investigating the causes of observed behaviours;
b) conducting and documenting more in-depth assessment of behaviours;
c) ensuring the required information is contained in the resident's plan of care relating to triggers, detailed descriptions of behaviours and interventions;
d) ensuring all care staff are familiar with the resident's plan of care, the specific interventions related to the behaviours and are consistent in the application and implementation of these interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours and (c) actions were taken to respond to the needs of the resident,

including assessments, reassessments and interventions.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The report stated that concerns had been brought forward regarding the care provided to a specific resident by an identified staff member. The report stated that one of the actions planned to correct this situation and prevent recurrence was revisions for the plan of care for the resident related to staff approach for their behaviours.

During an interview with an identified staff members they reported that this resident had a history of specific types of responsive behaviours. They said that concerns had been brought forward to them regarding the approach used by a specific staff member with this resident.

During an interview with another staff member they said that this resident had specific types of responsive behaviours and thought there were specific triggers. The staff member said they were not familiar with the interventions that were in place for this resident at the time. They said they had received a letter of discipline related to the incident and were required to complete re-education.

During an interview with the Behavioural Supports Ontario Registered Practical Nurse (BSO RPN) they said this resident had not yet been assessed by the BSO team and had not been part of the BSO program in the home. When asked what the process was for assessing residents with changes in behaviours or increased behaviours, the BSO said they would identify increased behaviours through reading the progress notes and reviewing the staff documentation. BSO RPN said they would then sit and talk about the behaviours and what could be done to decrease or address the behaviours but tended not to document those discussions. BSO RPN said that they tracked behaviours monthly on a statistics sheet in terms of the types of behaviours and when they were occurring, but did not summarize these in a progress notes or assessment forms for the residents. BSO RPN said this resident had specific types of behaviours and there were certain triggers and there certain interventions in place. BSO RPN said that staff were expected to look in the plan of care to know about behaviours and interventions.

The clinical record for this resident showed that there had been multiple incident of

responsive behaviours between their admission and the date of the CIS report. The clinical record did not include assessments or reassessments of the behaviours. The plan of care for the resident showed that the resident had behaviours but the plan of care did not include all the triggers or interventions that had been identified by staff during interviews or in the resident's progress notes.

During an interview the Resident Assessment Instrument Coordinator (RAI-C) they said that they were familiar with the incident and this resident. The RAI-C said that this resident had specific behaviours which required a specific type of approach from staff and that the type of approach taken during this incident would not have been the type of approach needed by this resident.

Based on these interviews and record reviews this identified resident was demonstrating frequent responsive behaviours between their admission to the home on and the Critical Incident. During the interviews various triggers for these behaviours were described and were not consistent with the triggers identified in the plan of care. The strategies that were developed to respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented assessments or reassessments. In addition, the actions taken specifically by a staff member as reported in the CIS report did not meet the needs of the resident related to responsive behaviours.

B) The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

The home submitted a Critical Incident System (CIS) report to the MOHLTC regarding an alleged incident of staff to resident abuse. The report stated that the resident had a history of responsive behaviours and at the time of the incident the resident was having a specific type of behaviour.

During an interview the BSO RPN said they were familiar with this resident and the resident had specific types of behaviours. The BSO RPN said that as the BSO team in the home they looked at the behaviours charted each week and then they would

sit down and talk about what things might work but they did not really document these discussions. The BSO RPN said they tracked the type and frequency of behaviours each month but this did not include the triggers or interventions or document an assessment of the trends or patterns identified.

During interviews with staff members they reported that this identified resident had a history of specific types of responsive behaviours. The staff members reported there were specific types of interventions that the resident required. They said that they had witnessed the incident between this identified staff member and the resident and that at the time the resident was showing specific responsive behaviours. The staff reported that the actions taken by this staff member did not meet the needs of the resident at the time regarding the behaviours.

The home's investigation documentation included a written statement by the staff member involved in the incident. This statement described the events leading up to the incident and the incident itself and described specific responsive behaviours that the resident was having at the time. The staff member reported that at the time they had taken specific actions related to the resident's behaviours.

The clinical record for this resident showed that there had been multiple incidents of responsive behaviours. The clinical record did not include reassessments of the behaviours. The plan of care for the resident showed that the resident had behaviours but the plan of care did not include all the triggers or interventions.

During an interview the RAI-C said they were familiar with this resident and that the staff in the home were monitoring their behaviours as they were starting to increase during a specific time frame. RAI-C said that at the time of the incident there had been a specific trigger for the resident's responsive behaviours and that the staff member had responded in a specific way which did not seem to meet the needs of the resident at the time. The RAI-C said that this staff member would have had access to the plan of care in PCC and the progress notes to know about this resident's behaviours and the interventions prior to the incident.

Based on these interviews and record reviews this resident was demonstrating frequent responsive behaviours prior to the Critical Incident. During the interviews various triggers for these behaviours were described, however these were not

consistent with the triggers identified in the plan of care. The strategies that were developed to respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented reassessments. In addition, the actions taken specifically by this staff member as reported in the CIS report did not meet the needs of the resident related to responsive behaviours. [s. 53. (4)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of the issue was a level 2 as it affected 2 out of 3 residents reviewed. The home had a level 2 compliance history as they had no history of non-compliance with this section of the legislation. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2019

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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 8 th day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMIE GIBBS-WARD (630) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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