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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 19, 2018	2018_610633_0002	001736-18	Resident Quality Inspection

Licensee/Titulaire de permis

Golden Years Nursing Homes (Cambridge) Inc.
704 Eagle Street North P.O. Box 3277 CAMBRIDGE ON N3H 4T3

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

Golden Years Nursing Home
704 Eagle Street North P.O. Box 3277 CAMBRIDGE ON N3H 4T3

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

SHERRI COOK (633), APRIL TOLENTINO (218), INA REYNOLDS (524), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 22-26, 29-31. February 1, 2, 5, 7, 8, 9, 2018.

The following inspections were conducted concurrently during this inspection:

Log #021277-16/1033-000015-16- Critical Incident related to alleged abuse.
Log #025053-16/1033-000022-16- Critical Incident related to medication administration.

Log #010375-16/1033-000010-16- Critial Incident related to alleged abuse.
Log #022910-16/1033-000019-16- Critical Incident related to responsive behaviours.
Log #019322-16/1033-000013-16- Critical Incident related to alleged abuse.
Log #001673-16/1033-000004-16- Critical Incident related to alleged abuse.
Log #029032-17/SAC 17879/1033-000028-17- Critical Incident related to responsive behaviours.
Log #023131-17/SAC 17003/1033-000015-17- Critical Incident related to responsive behaviours.
Log #026960-17/1003-000023-17- Critical Incident related falls prevention.
Log #024738-17/1003-000016-17- Critical Incident related falls prevention.
Log #015561-17/SAC 16199/1033-000007-17- Critical Incident related to alleged abuse.
Log #023356-17/1033-000014-14- Critical Incident related to responsive behaviours.
Log #027360-17/1033-000024-17- Critical Incident related to falls prevention.
Log #026573-17/1033-000025-17- Critical Incident related to alleged abuse and plan of care.
Log #015357-17- Follow-up to Orders #001, #002 and #003 from inspection 2017_600568_0007 related to alleged abuse, maintenance and reporting to the Director.
Log #025978-17/1033-000022-17- Critical Incident related to alleged abuse.
Log #026607-17/1033-000020-17- Critical Incident related to alleged abuse.
Log #023259-17/1033-000013-17- Critical Incident related to alleged abuse.
Log #025240-17/SAC 17374/1033-000021-17- Critical Incident related to alleged abuse.
Log #014072-17/IL-51649-LO/1033-000004-17- Complaint and Critical Incident related to alleged abuse.
Log #028987-17/IL-54605-LO- Complaint related to alleged abuse and plan of care.
Log #011622-17/IL-51293-LO- Complaint related to plan of care.
Log #029675-17/IL-54737-LO- Complaint related to alleged abuse.
Log #029452-17/IL-54716-LO- Complaint related to plan of care and responsive behaviours.
Log #000611-18/SAC18147/1033-000001-18- Critical Incident related to responsive behaviours.
Log #001291-18/1033-000003-18- Critical Incident related alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Vice President of Clinical Services, the Executive Director, the Administrator, the Director of Care, the Assistant Director of Care, the Director of Environmental and Food Services,

the Director of Programs, Registered Nurses, a Resident Assessment Instrument Coordinator, a Social Worker, a Pharmacy Technician, Registered Practical Nurses, Behavioural Supports Ontario/Registered Practical Nurse, Behavioural Supports Ontario/Personal Support Workers, Personal Support Workers, a Dietary Aide, a Maintenance Worker, a Resident Council member, a Family Council member, residents and family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Additionally, the inspector(s) observed medication administration and drug storage areas and reviewed the home's medication incidents and observed resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **1 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. 90. (1)	CO #002	2017_600568_0007	633

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) that identified an incident of staff to resident abuse which occurred on a specific date. The CIS report stated that there were two staff witnesses.

The plan of care in PointClickCare (PCC) stated that the identified resident had a Cognitive Performance Score (CPS) which indicated a moderate cognitive impairment. The care plan dated on a specific date stated that there were specific interventions in place when the resident was demonstrating specific behaviours.

During an interview on a specific date, two staff members said that they witnessed the incident. One staff member also said that they were bothered by what they saw and they reported the incident to their Manager. The other staff member said that they observed the resident demonstrating behaviours and the resident also appeared afraid.

During an interview on a specific date with the identified staff member involved they said that the resident was demonstrating behaviours and they did not recall that abuse occurred. The employee file for the identified staff member and the home's investigation records stated that a disciplinary action was taken related to this incident.

During an interview on a specific date with the Director of Care (DOC) and the Assistant Director of Care (ADOC) they acknowledged that abuse did take place by the identified staff member towards the identified resident.

The licensee has failed to ensure that an identified resident was protected from abuse by an identified staff member on a specific date. [532]

2. Ontario Regulation 79/10 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The home's “Definitions of Abuse 005010.00a” dated May 2016, defined neglect as stated above.

A CIS was submitted to the MOHLTC that stated that an identified staff member failed to provide specific care to six residents on a specific shift and date.

The home's investigation records documented the condition that the six residents were found in on the next shift.

Written statements related to the incident, that were completed and signed by oncoming staff members, stated that they had found the six identified resident's in the condition as described in the home's investigation records.

The Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) Assessments previous to the incident related to specific care and the care plans in PCC stated that the six identified residents all required specific interventions and assistance from staff. The care plans also documented that four residents were considered at risk for impaired skin integrity.

The progress notes in PCC stated that one identified resident sustained altered skin integrity as a result of the incident and they were referred to the Physician for further treatment. There was no further documentation in PCC for the other five residents.

Resident interviews were attempted on a specific date. Four residents were not interviewable and two residents were discharged from the home for reasons unrelated to this incident.

During staff interviews on a specific date four staff members corroborated the incident. One staff member stated that there had been previous incidents of a similar nature involving the same identified staff member. The four staff members agreed that not providing a specific care for a resident was a form of neglect.

During an interview on a specific date with the identified PSW they acknowledged that they did not provide a specific care for three identified residents. They explained that they were too busy performing a housekeeping task and they understood that resident care should have been the priority. The staff member also said that they failed to document and report the conditions in which they left the residents to the oncoming staff.

During an interview on a specific date with the DOC and ADOC, the DOC stated that they considered no documentation of resident care as care not provided. The DOC also stated that they had no tolerance for abuse or neglect at the home and both the DOC and the ADOC considered this incident as staff neglect towards the six identified residents. The identified staff member received an unpaid suspension related to this incident.

The licensee failed to ensure that six residents were not neglected by an identified staff member on a specific date. [218]

3. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A CIS stated that on a specific date an identified resident reported that a staff member caused them a specific injury. The CIS further stated that the resident was receiving a specific intervention and their cognition was intact. The CIS also stated that the resident was not able to provide details regarding the staff member involved.

A photo in PCC on a specific date showed a specific injury to the resident. The plan of care in PCC stated that the identified resident had specific diagnoses and their cognition was borderline intact. A progress note in PCC on a specific date for the identified resident stated their account of the incident and that the Manager on call was notified of the incident by staff.

The home's investigation notes included a summary of the incident dated on a specific date by the DOC and they indicated that they interviewed staff and no disciplinary action was taken. The DOC also identified in their report that the resident required assistance from staff for specific care and that the resident was unable to describe anything about any of the people who allegedly were in the room despite knowing regular staff by name. Staff who were working that day were questioned by the DOC and denied being a part of or witnessing the incident. The DOC also stated that the resident had a specific device and it was possible that they were injured by this intervention.

During an interview on a specific date with the identified resident they restated repeatedly their account of the incident and demonstrated how the staff member injured them. The resident also stated that they communicated the incident with staff members. They resident expressed again that it was two staff members present and it was one of the staff members that injured them. The resident also shared that staff were redirected since this incident as they were now assisting them differently. The resident reiterated that it was painful initially and then the pain went away.

During an interview on a specific date a staff member shared that they did not provide care to the identified resident as the resident had refused. The staff member said that the resident told them about the incident and showed them their injury. The staff member explained that the resident also said to them that they had said “ouch”. The resident also

stated that the incident happened between a specific time period. The staff member agreed that there was an injury to the resident and they had reported this to the registered staff.

During an interview on a specific date a staff member said that the resident showed them their injury the next day and told them that staff did it. The staff member said that they were shocked by the injury as it was quite extensive. They also said that the resident was competent and knew the staff but the resident did not know all of the staff by their names.

During interviews on a specific date two staff members shared that staff had reported the incident to them. The staff members said that the resident reported that the incident occurred during care and they were injured then. The resident also said that there were two staff members present in the room. The staff member stated that there was no description provided by the resident of the staff involved and they had informed the Registered Nurse (RN) right away. The RN explained that the resident showed them their injury and they had thought that it looked new to them. The RN also said that they completed an assessment, documented everything that the resident had told them and notified the on call Manager. The RN also said that they interviewed staff and they did not know about the incident. The RN shared that the resident had not injured themselves in the past in anyway.

During an interview with the Director of Environmental and Food Services (DEFS) on a specific date, they said that they were on call at the time of the incident and they had informed the DOC right away by text from their personal phone. The DEFS showed the text to the Inspector and it stated that the resident was upset that two staff had provided them care and one had injured them. The DOC responded by text and stated "ok thanks….will look into it tomorrow".

During an interview on a specific date the DOC said that the resident was on a specific intervention and their skin was thin. The DOC also stated that it was not until they looked into this incident further that they realized that it was an allegation of abuse. The DOC explained that when they spoke to the resident they were almost dismissive of them and they had told them that there were three staff members present and they would not give them the names of the staff involved. The resident told the DOC that they would have said “ouch”. The DOC also said that they reproached the resident on another date to ask the resident again about the details of the incident. The DOC explained that the resident repeated the same account of the incident. The DOC stated that they only interviewed

determined that no staff were identified as having a role in this injury to the resident and therefore no disciplinary action was taken. The DOC acknowledged that they did not interview all staff. The DOC said that they thought that the injury to the resident was potentially caused by their device and had spoken to the Occupational Therapist (OT) regarding this device.

During another interview on a specific date with the identified resident regarding the incident they relayed the same account of events at least three times to the Inspector. When the resident was asked if there was a possibility that their injury was related to their device the resident was adamant that they did not injure themselves with their device. The resident was able to demonstrate how they were able to use their device. The resident was upset that their device was even suggested as a potential cause of their injury and again they repeated and verified that staff had caused their injury.

The People Care policy "Abuse/Neglect Employee 004060.00", not dated, stated “signs and symptoms that a resident has been or was being abused included unexplained physical injury.”

During an interview with the DOC on a specific date they said that they were misinformed by staff related to this incident as they were told that the resident was injured related to repositioning. The DOC explained that it was not communicated to them by staff that there was an allegation of abuse.

The licensee has failed to ensure that an identified resident was protected from abuse by anyone. [532]

4. Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A CIS related to the alleged abuse of an identified resident was submitted to the MOHLTC by the DOC on a specific date. The CIS stated that the resident sustained specific injuries that were related to possible neglect and physical abuse. The CIS further stated that the resident experienced increased pain and decreased mobility as a result of their injury.

The photos in PointClickCare (PCC) for the identified resident that were taken on specific

dates showed extensive injuries. The plan of care in PCC stated that the resident required total assistance for care and mobility and two staff with a specific device for transfers for specific care. The progress notes in PCC documented the incident and the resident's injuries over time on specific dates.

During an interview with the identified staff member they said that they were assisting the resident alone while providing a specific care on a specific date and the resident was injured. The staff member agreed that they were using the incorrect device and they also acknowledged that the resident required two persons for the transfer for this specific care. The staff member denied that the injury of the identified resident was a result of their transfer with the incorrect device. They also said that they had reported the incident to the Charge Nurse.

During an interview with a staff member they said that they answered the call bell for the identified resident on a specific date and they witnessed the resident in the incorrect position and transfer device. The staff member also said that the staff member was assisting the resident alone. The staff member stated that they did not report their account of the incident to the registered staff as they had told the identified staff member to do so. The staff member stated that when they returned to work five days later the resident looked worse. They also said that they had thought that something else could have occurred and wondered if the incorrect device had been used again. They agreed that it was not until five days later that they told the DOC of their account of the incident that occurred on a specific date.

During an interview with a registered staff member on a specific date they said that they were the Charge Nurse when the incident occurred. They explained that the two staff members did not report to them the details of the incident that included the use of the incorrect transfer device by only one staff member. They also stated that they noticed that the resident had altered skin integrity on a specific area and they did not complete a head to toe assessment of the resident for other injuries as they did not know to do so. The registered staff member also said that they reported the limited information that they knew to the Vice President of Clinical Services (VP) and were told to initiate a specific intervention. They agreed that an unsafe transfer that resulted in the resident's significant injury would be considered improper care and incompetent treatment of a resident.

During an interview with a staff member on a specific date they said that they they provided care to the identified resident at a specific time and date. They explained that they saw the residents injury and were alarmed and scared with what they saw. They

also said that they reported their concern to the registered staff immediately. The staff member also stated that they had witnessed the resident's injury again at a specific time and date and they had reported to the same registered staff again of their concern that the injury of the resident had become much worse. They denied suspecting that abuse of the resident had or may have occurred however, they did state that they wondered if the incorrect device was being used to transfer the resident or if the resident had fallen.

During an interview with the registered staff member they said that they worked on three specific dates and they were aware from shift report that the resident had an incident. They also stated that they were informed of the injury of the identified resident by staff on a specific date and they had referred to the resident's chart, confirmed the incident and noted that the resident was not receiving a specific intervention and was not a falls risk due to their lack of independent mobility. They said that they observed the injury, however they did not asses the resident's injuries fully or take photos as the resident had been recently dressed by the staff. The registered staff member said that it was not until two days later that they removed the incorrect transfer device from the resident's room and documented in PCC for staff to use a specific device for all transfers. They explained that it was not until a specific date that they assessed the injury and took photos. They stated that they did not report the injury and condition of the identified resident to the Manager on call and they agreed that they should have. They reviewed the plan of care for the resident in PCC and they were unable to locate a completed specific assessment. They explained that they recalled completing a paper assessment however the assessment was incorrectly entered into PCC and staff were not prompted to complete this task. They agreed that an improper transfer that resulted in the injury sustained to the resident would be considered incompetent treatment and care of a resident.

During an interview with a staff member on a specific date they said that they worked a specific shift and recalled the injury on the identified resident. They also said that they were unaware of the incident that had occurred. They agreed that the resident had not had an injury like that in the past and they agreed that abuse may have occurred. The staff member explained that they did not report the resident's injury or their concern to Management as they had understood that staff had already reported to them.

During an interview with the DEFS on a specific date they said that there were on call on specific dates and they were unaware of the incident related to the identified resident that occurred on a specific date, or the significant injury that developed on the three days after. When they were shown the photos of the injury they said that an unsafe transfer that resulted in the injury to the identified resident was incompetent treatment of a

resident and the expectation would be that staff reported both the incident and the injury to Management on call when after hours.

During interviews with the VP, Administrator, DOC and ADOC on specific dates they all said that no staff had reported the details of the incident that included the unsafe transfer of the resident, however the VP and DOC did state that they were aware that the resident had an incident and may have hit their specific body part. They all also said that they were not unaware of the injury which developed over the next days. The DOC explained that they returned to work and they observed the injury of the resident then and they had determined that the origin of the residents injury was an unknown cause and not alleged or potential abuse. The DOC explained that it was not until the next day, five days later, when a staff reported to them that the resident had an incident with their device that they had determined that an unsafe transfer had occurred by the identified staff member that had resulted in the significant injury of the resident. The VP and DOC both agreed that the resident required a specific transfer device with two staff assistance as the resident was unable to hold their own weight. They also said that the staff member did not follow the plan of care for this resident and an unsafe transfer had occurred. They also stated that the injury to the resident did not just suddenly appear and that many staff were aware and had not reported to them. The VP also said that they advised the RN to initiate a specific assessment. The VP stated that after the initial assessment, they were unable to locate a completed paper assessment in the resident's chart or a summary progress note in PCC. The VP explained that the expectation was that the assessment be completed for 72 hours and this was not completed and should have been.

The People Care policy "Abuse/Neglect Employee 004060.00", not dated, stated “signs and symptoms that a resident has been or was being abused included unexplained physical injury.”

The home's policy "Nursing-Zero Lift and Transfer Program 007020.00" stated that:
-"All staff will follow the required lift procedure outlined on the care plan/bedside logo of each resident at all times.
-All staff are responsible to report any unsafe acts.
-Two staff must be in constant attendance for all lifts/transfers
-Staff cannot make the decision to decrease the amount of assistance required for a transfer until the resident was assessed by a physiotherapist.
-For a mechanical lift and Sit/Stand lift two caregivers must be present during the lifting procedure."

The employee file for the identified staff member included a written notification letter that stated that they did not follow the plan of care for the resident related to their transfer device and level of assistance required for specific care. The VP and the identified staff member both confirmed that the staff member no longer worked at the home.

The licensee has failed to ensure that an identified resident was provided with the treatment, care, services or assistance required for health, safety or well-being, that included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

1. A CIS was submitted to the MOHLTC on a specific date and time that was related to an incident of alleged resident to resident abuse. The CIS stated that the identified resident received an injury as a result of an incident.

The home's People Care policy "Abuse or Suspected Abuse/Neglect of a Resident" 005010.00, not dated stated the following in part:
-"That all staff have an obligation to report any incident or suspected incident of resident abuse.
-Employees who fail to report any incidents or concerns shall be disciplined.
-Employee was to notify the charge nurse.
-Charge Nurse were to notify the RN and notify the DOC/ED immediately.
-That the ED or designate would notify the Director immediately".

In an interview with the DOC on a specific date they stated that management were not aware of the incident until the next day at the morning huddle with the multidisciplinary team. The DOC said that the expectation for staff related to reporting alleged abuse was that the RPN would report to the Charge Nurse and the the Charge Nurse was to immediately report the incident to Management. The DOC said that Management would then immediately call in the CIS if after hours or complete the CIS Report online if during business hours. The DOC agreed that this process had not been followed by staff and this incident was not reported to the Director immediately as required and should have been.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of an identified resident by anyone that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

2. A CIS was submitted to the MOHLTC that identified a staff to resident abuse that occurred on a specific date. The CIS was not submitted to the Director immediately. The CIS further stated that there were two staff witnesses and the situation had escalated.

The home's investigation records stated that the incident occurred on a specific date and the two staff witnesses did not report the incident immediately to the Charge Nurse. The incident was reported to ADOC the next day and the DOC did not report to the Director until six days later.

During interviews on specific dates the two staff members shared that they witnessed the incident and agreed that they did not report the incident to their Manager until the next day and they did not complete a CIS to the Director immediately.

During an interview on a specific date the ADOC shared that they became aware of the incident the next day. The ADOC said that both staff were asked by them to provide a written statement which went to the DOC however the DOC was away at the time. The ADOC also said that in retrospection, they should have investigated the incident immediately but being new to their role and learning they did not realize at the time to immediately investigate and report to the Director as required.

During an interview on a specific date the DOC shared that they had re-educated all their staff in relation to abuse. The DOC stated that there was a trend or culture of complacency in the home related to staff not reporting alleged abuse to Management. The DOC acknowledged that they did not notify the Director immediately as they were under the impression that they could gather the information and complete the investigation before notifying the Director. The DOC said that they now knew that they were to immediately report incidents of abuse to the Director as required.

The licensee failed to immediately report the alleged abuse of and identified resident by an identified staff member and the information upon which it was based to the Director. [s. 24. (1)]

3. A CIS related to the alleged abuse of an identified resident was submitted to the MOHLTC by the DOC four days after the incident of alleged abuse occurred. The CIS stated that the resident sustained injuries related to possible neglect and physical abuse on a specific date, and the resident experienced increase pain and decreased mobility as a result of their injury.

During an interview with the identified staff member on a specific date they said that they did not provide the resident the level of assistance required for a specific care and they were also using the incorrect device. The staff member also said that they reported the

incident to the Charge Nurse and they did not complete mandatory reporting to the Director as their role was to report the incident to the registered staff.

During an interview with a staff member on a specific date they said that they witnessed the resident in the incorrect position and device. They also said that the level of assistance required for a specific care was not provided to the resident. The staff member stated that they did not report the incident to the registered staff as they had told the identified staff member to do so. They also said that they did not complete mandatory CIS reports to the Director and they were unsure of who did.

During an interview with a staff member on a specific date they said that they were working the a specific shift and had provided the resident care at a specific time. They explained that they saw the injury and had immediately informed the Charge Nurse who came and also witnessed the residents injury. The staff member stated that they did not complete mandatory reporting to the Director as their role was to inform the registered staff.

During an interview with a registered staff member on a specific date they said that they worked on specific dates and were aware from shift report that an incident occurred. They also stated that they were informed of the residents injury at two separate times and they did not call the Manager on call. They also acknowledged that they should have informed Management and they did not. They also said that they did not report to the Director as this this was the role and at the discretion of Management.

During an interview with a staff member on a specific date they said that they worked a specific shift and date and recalled the injury of the identified resident. The staff member explained that they did not report the resident's injury or their concern to Management as they had understood that staff had already reported to them. They also did not report to the Director as they said this was the role of Management.

During an interview with the DEFS on a specific date they said that they were on call on specific dates and they were unaware of the incident and injury related to the identified resident. They said that the expectation was for staff to call them when after hours as they were on call. They further stated that they would contact the Administrator or the DOC to complete the CIS report to the Director as required as they were not a nurse.

During interviews with the Administrator, DOC and ADOC on specific dates they all said that no staff had reported the full details of the incident to them however the DOC did

state that they were aware that an incident had occurred. They all also said that they were unaware of the injury that occurred in the three days after the incident. The DOC explained that they witnessed the significant injury and had determined the origin of the residents injury as "unknown cause" and not alleged or potential abuse and therefore they did not complete a mandatory CIS to the Director immediately as required. The DOC acknowledged that they did not report to the Director until five days after the incident occurred.

During an interview with the the VP and the DOC on a specific date they explained that the process in the home for reporting incompetent treatment/alleged abuse was that the PSW's reported to the registered staff and the Charge RN would report to the DOC if during business hours or staff were to call the on call Manager if after hours. They also said that the expectation related to reporting to the Director was immediately. The DOC said that the process in the home for reporting to the Director was that they, the Administrator and possibly the ADOC completed all the mandatory reporting to the Director. The VP explained that there was an on-going culture in the home of staff not reporting to Management despite the education that had been provided to all staff by the home. The VP, DOC and ADOC all said that staff should have reported to them and they did not.

The policy "Abuse/Neglect Employee 004060.00", not dated stated that signs and symptoms that a resident had been or was being abused included "unexplained physical injury". Under the sub heading "Prevention" it was stated that "5. Employees are to report all injuries whether the cause is known or unknown". The policy further stated that the "nurse manager will immediately advise the ED and DOC upon receiving a report of suspected abuse".

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the improper or incompetent treatment or care of and identified resident that resulted in harm or a risk of harm to the resident was immediately reported with the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

4. A CIS was submitted to the MOHLTC on a specific date and stated that an incident of alleged staff to resident abuse occurred on a specific date. The CIS further stated that an

identified resident reported that staff caused them an injury.

The progress notes in PCC on a specific date stated that the resident reported to a specific staff member that they were injured as a result from a staff member while providing personal care. This note also documented that the Manager on call was informed. The staff member did not report to the Director as required.

During an interview on a specific date with the DEFS they shared that the registered staff member had notified them regarding the incident. They said that they had informed the DOC by text and they were told by the DOC by text that they would look into it the next day. They also said that the expectation was to call the MOHLTC after hour number immediately however they did not call or submit a CIS report to the Director as required.

During an interview on a specific date the DOC was asked about the late report to the Director once they were aware of the alleged abuse incident. The DOC replied that when they received the phone call from the DEFS they were misinformed concerning the incident. The DOC acknowledged that the reporting of the alleged abuse to the Director was late. The DOC also said that it was their understanding to collect the information related to abuse, start the investigation and then submit the CIS to the Director. The DOC further stated that they now understood that they were to immediately report incidents of abuse to the Director as required.

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the improper or incompetent treatment or care of an identified resident that resulted in harm or a risk of harm to the resident was immediately reported with the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

5. A CIS was submitted to the MOHLTC five days after a staff member witnessed an incident of rough care towards an identified resident by an identified staff member on a specific date. The CIS stated that the resident was upset.

During an interview with the DOC on a specific date they stated that a staff member reported the allegation to them five days after the alleged incident. The DOC also said that they started the investigation, looked into the allegations and reported the

information to the Director when they became aware of the alleged abuse. The incident was not reported immediately to the Director by the staff member as required.

The licensee failed to immediately report the alleged abuse of and identified resident by an identified staff member and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. LTCA 2007, c. 8, s. 20 (1) states that "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."

The home's People Care policy "Abuse or Suspected Abuse/Neglect of a Resident" 005010.00, not dated stated the following in part:
-"That all staff have an obligation to report any incident or suspected incident of resident abuse.
-Employees who fail to report any incidents or concerns shall be disciplined.
-Employee was to notify the charge nurse.
-Charge Nurse were to notify the RN and notify the DOC/ED immediately.
-Investigation was to begin immediately.
-That the ED or designate would notify the Director immediately
-That the Charge RN would obtain written statements from all witnesses and document account of the incident using the Incident Report Form
-It was recommended that the RN initiate the "Nursing Checklist for reporting/investigation" alleged abuse of a resident.
-Attachment 005010.00 (b) "Nursing Checklist for Reporting and Investigating Alleged Abuse".

The home's policy “Mandatory/Critical Incidents 003400.00” stated in part that:
-"It is the policy of peopleCare to document and report all incidents.
-Utilize the Decision Trees as a tool to guide decision-making about the need to notify the Director or handle as an internal investigation. Document answers to questions in Decision Tree and file as part of the investigation".

The home's Abuse Program annual evaluation dated April 2017, stated in part that:
-When completing an investigation use the “Investigation Report" for documentation.
-There was a recommendation documented to include a statement in the Abuse policy that during an investigation “record on the investigation report all the details” and “highlight the form on the policy for easy retrieval".
The 2017 Abuse Program evaluation stated that this change was made on May 16, 2017.

On two specific dates the DOC explained the education to staff related to alleged abuse and mandatory reporting and they showed inspectors the poster board "Learn to Recognize a Critical Incident, Golden Years CI Defined". The poster contained decision trees for abuse, a nursing checklist for reporting/investigating alleged abuse of a resident, a Critical Incident (CI) policy, a Mandatory CI report checklist that included abuse/neglect mandatory report, the after-hours contact for the Manager on call and timelines for reporting.

1. A CIS was submitted to the MOHLTC that described an incident of neglect by a staff member towards multiple residents. The investigation records included statements obtained from staff by the DOC that were handwritten and an interview completed with the accused staff member that was documented electronically using a Microsoft Word Document. The home’s investigation records did not include a "Nursing Checklist, Incident Report Form" initiated by an RN per the home's policy to document the written statements obtained from the witnesses involved at the time of the incident and an "Investigation Report" to document the investigation was not included.

During an interview with the DOC on a specific date they stated that their investigation notes were captured and described in the CIS report submitted to the Director. [218]

2. A CIS identified a staff to resident abuse that occurred on a specific date. The home’s investigation records did not include statements from two staff at the time of the incident and their statements were taken after an interview with the DOC. The RN in charge did

not obtain written statements from witnesses and document the staff account of the incident using the "Incident Report Form". A "Nursing Checklist" was not included in the home's investigation records, an "Investigation Report" for documenting investigations was not present and answers to questions in the Decision Tree were not filed as part of the investigation.

During an interview with a registered staff member they indicated that they were not interviewed as part of the investigation and did not provide a written statement.

During an interview with the Administrator and DOC on a specific date they both said that there was no further documentation related to this incident involving the identified resident.

In an interview on a specific date the ADOC acknowledged that they were new to the role and were learning the process for investigating alleged abuse. [532]

3. A CIS stated that an identified resident reported that a staff member had caused them an injury on a specific date.

The home's investigation records did not include a written statement from four staff members. Statements from two staff were completed after interviews with the DOC. The RN in charge did not obtain written statements from all staff at the time of the incident nor did they document their account of the incident using the "Incident Report Form". A "Nursing Checklist", an "Investigation Report" for documenting investigations and answers to questions in the Decision Tree were not filed as part of the home's investigation.

During an interview with a registered staff member they indicated that they were not interviewed as part of the investigation and did not provide a written statement.

During an interview with the Administrator and DOC on a specific date they both said that there was no further documentation related to the incident involving the identified resident.

4. A CIS related to alleged abuse of an identified resident was submitted to the MOHLTC by the DOC on a specific date. The CIS stated that the resident sustained significant injuries after a staff member was assisting them alone on a specific date.

The investigation records only included statements from staff after interviews with the DOC and many of these statements were not dated. The home’s investigation records did not include statements obtained from the Charge Nurse that were documented on an “Incident Report Form”, a "Nursing Checklist" was not included and an “Investigation Report” for documenting investigations was not completed.

During an interview with the Administrator and DOC on a specific date they both said that there was no other further documentation related to the incident involving the identified resident.The DOC agreed that a "Nursing Checklist, CI Mandatory Report Form or Incident Report Form" as stated in the home's Abuse policy were not completed related to the incident involving this resident and answers to questions in the Decision Tree were no filed as part of the home's investigation.

During an interview with a registered staff member they said that they do not do investigations, take statements or complete a nursing checklist. They also said that RN’s do not complete this documentation either. They said that they would complete an internal complainant form and leave it for the DOC. They agreed that they had been provided training related to abuse by use of a poster board that contained the "Nursing Checklist" and a "Mandatory CI Report Checklist".

During interviews with two RN’s on specific dates they both said that they did not complete abuse investigations and related documentation as their role was to report the incident/allegation to the DOC.

During an interview with the ADOC on a specific date they stated that the documentation related to alleged abuse investigations included the "Nursing Checklist" and did not include the "Investigation Form" or the "CI Report Checklist". The ADOC explained that their understanding was that they could look at the checklists and could choose which one was relevant and this would be the documentation completed for alleged abuse investigations.

During an interview with the Administrator and DOC on a specific date, who reviewed the education board posted in the private dining room, the DOC agreed that staff had been provided education with this tool and the poster board was available for the staff for continued access. This board contained the "Nursing Checklist" and the "Mandatory CI Report Form" and did not include the "Investigation Report Form". The DOC shared that she was not aware of the "Nursing Checklist" and said that the staff were not completing them. The DOC also stated that they thought that the "Mandatory Critical Incident (CI)

Report" and "Nursing Checklist" were the same.

During the exit debrief of the home on a specific date the VP stated that the expectation for documentation related to abuse investigations was to follow the abuse policy. The VP also said that they understood that the "Nursing Checklist, Critical Incident Report Form and the Incident Report Form" were tools that staff could use and they would change the policy so that staff may use these forms or not. The VP also agreed to review the home's Abuse policy and associated forms/checklists to determine the documentation required in the home related to alleged abuse reporting and investigations.

2. LTCHA 2007, c. 8, s. 20 (2) states in part that "at a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(d) shall contain an explanation of the duty under section 24 to make mandatory reports".

LTCHA 2007, c. 8, s. 24 (1) states in part that "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

Three policies related to abuse or alleged abuse/neglect of a resident and mandatory reporting to the Director were provided by the DOC and Administrator. They both stated that these abuse policies were currently used in the home. The home's policies "Abuse or Suspected Abuse/Neglect of a Resident 005010.00", "Abuse and Neglect (Employee) 004060.00 and "Mandatory/Critical Incidents 003400.00", that were not dated, did not contain an explanation of the duty under section 24 to make mandatory reports.

During interviews on specific dates with four Personal Support Workers (PSW's) and two Registered Practical Nurses (RPN's) all said that they did not complete Critical Incident System (CIS) Reports or call the after-hours pager to report alleged abuse incidents to the Director as their role was to report to the Charge Nurse. One PSW said that they did not know who completed CIS reports. Two Registered Nurses (RN's) both said that Management looked after the reporting to the Director and they did not compete CIS reports or call the after-hours pager. Both RN's also said that they would call the on call Manager if the incident occurred after-hours.

During an Interview with the DEFS on a specific date they said that at times they were the on call Manager on the weekends and if a staff member called them to report alleged abuse they would call or email the DOC or Administrator. They also said they did not complete CIS reports.

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

During an interview with Vice President of Clinical Services (VP) and DOC on a specific date they said that the expectation for staff related to reporting alleged abuse was to inform their Manager immediately if they were present at the home or staff were to call the Manager on call if the incident was after hours. They also said that the expectation of the home was that all alleged abuse was reported to the Director immediately and this was completed by Management who completed the CIS Reports to the MOHLTC. The VP explained that there were on-going issues related to staff not reporting allegations of abuse of a resident to Management immediately.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports to the Director. [s. 20.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations.

Two of the home's investigations related to allegations of abuse/neglect were not initiated immediately.

Ontario Regulation 79/10 s.2 (1) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

1. A CIS identified a staff to resident verbal abuse which occurred on a specific date. The CIS report stated that two staff overheard an identified staff member yelling profanity at an identified resident.

During an interview on a specific date a staff member shared that they heard profanity that was directed at the identified resident. They indicated that the incident bothered them and as a result they reported to their Manager the next day. They explained that they had reported the incident to the ADOC and also submitted a statement to the DOC

under their office door.

During an interview on a specific date a staff member said they witnessed the incident and reported to the ADOC the next day when they came on shift. The RPN said that the ADOC suggested that they put their statement in writing under the DOC's office door.

Record review of the home's investigation records indicated that the incident of verbal abuse occurred on a specific date by an identified staff member towards an identified resident and the incident was reported to ADOC the next day. Statements from two staff were submitted under the DOC's door on a specific date however the DOC was on holidays at the time and the incident was not investigated until six days after the incident had occurred.

During an interview on a specific date the ADOC said that they became aware of the incident the next day. The ADOC indicated that the two registered staff came to them and voiced that they had heard a verbal exchange between the resident and staff member. The ADOC explained that the two staff may have mentioned that staff may have used profanity and yelled but they did not mention to them that this was directed at the resident. The ADOC said that both staff were asked by them to provide a written statement which went to the DOC under their office door. The ADOC acknowledged that they did not investigate the incident immediately and because the DOC was away at the time, the DOC did not investigate until they returned. The ADOC said that in retrospection they should have investigated the incident immediately.

During an interview on a specific date the DOC was asked why the incident of verbal abuse by was not investigated immediately when they had become aware and they acknowledged that they did not start the investigation immediately as they were not aware of the protocol to investigate allegations of abuse immediately.

The licensee has failed to ensure that the witnessed incident of verbal abuse by a staff member towards a resident was immediately investigated. [s. 23. (1) (a)]

2. A CIS stated that that an identified resident reported that an identified staff member had caused them an injury while providing them care.

The home's investigation records included statements by staff on a specific date and the CIS report was initiated and documented on a specific date.

The home's policy "Abuse or Suspected Abuse/Neglect of a Resident" 005010.00, not dated stated in part that the investigation was to begin immediately. The home's policy "Abuse & Neglect (Employee)", not dated stated that "the Nurse Manager, Executive Director and Director Resident Care will collaborate to determine how to proceed with the investigation. Investigation will commence immediately."

During an interview on a specific date the DOC was asked about the late investigation once they became aware of the abuse allegation and the DOC replied that when they received the phone call they were misinformed concerning the incident. The DOC said that it was not communicated to them that there was an allegation of abuse. The DOC acknowledged that alleged abuse investigations were to begin immediately however their understanding was that they could collect information and then start the investigation. The DOC acknowledged that they were not were not aware of the protocol for investigating alleged abuse.

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported is immediately investigated, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) Report related to the alleged abuse of an identified resident was submitted to the MOHLTC by the DOC on a specific date. The CIS stated that the resident sustained multiple injuries related to possible neglect and physical abuse. The CIS further stated that the resident experienced increase pain and decreased mobility as a result of their injury.

The care plan in PCC stated that the resident required total assistance of staff with transfers with a specific device for specific care.

During an interview with the identified staff member on a specific date they said that they did not provide the resident the level of assistance required for a specific care and they were also using the incorrect device.

During an interview with a staff member on a specific date they said that they witnessed the resident in the incorrect position and device.

The home's policy "Nursing-Zero Lift and Transfer Program 007020.00" stated that:
-"All staff will follow the required lift procedure outlined on the care plan/bedside logo of each resident at all times.
-All staff are responsible to report any unsafe acts.
-Two staff must be in constant attendance for all lifts/transfers
-Staff cannot make the decision to decrease the amount of assistance required for a transfer until the resident was assessed by a physiotherapist.
-For a mechanical lift and Sit/Stand lift two caregivers must be present during the lifting procedure."

The employee file for the identified staff member included a written notification on a specific date that stated that they did not follow the plan of care for the resident related to their transfer on a specific date and this resulted in an injury to the identified resident.

During an interview with the VP and DOC on a specific date, the VP stated that they had checked the transfer logo in the resident's room at the time of the incident and the correct logo had been applied that indicated the correct device and level of assistance from staff required. The VP and DOC both agreed that the identified staff member did not follow the plan of care for this resident and an unsafe transfer had occurred. The VP and the identified staff member both confirmed that the staff member no longer worked at the home.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting an identified resident on a specific date. [s. 36.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Two substitute decision-makers (SDM's) were not notified within 12 hours of an allegation of abuse or neglect of a resident.

1. A CIS was submitted to the MOHLTC that identified a staff to resident verbal abuse

which occurred on a specific date. The CIS report stated that two witnesses overheard a staff member yelling, which included profanity, at the resident.

The home's investigation records indicated that the incident of verbal abuse occurred but the incident was not reported to the ADOC until the next day. The investigation records document that the resident's substitute decision maker (SDM) was not notified until six days after the incident had occurred.

During an interview on a specific date a registered staff member acknowledged that they were not made aware of the incident. The RN said that they had called the Physician to get a medication order; however, they did not notify the Manager or the SDM related to the verbal abuse incident as they were not aware.

The home's policy "Abuse or Suspected Abuse/Neglect of a Resident 005010.00" stated that the RN in charge will "notify the SDM immediately if there has been physical harm, pain or distress. The SDM must be notified within 12 hours of any alleged, suspected or witnessed abuse".

During an interview on a specific date the DOC acknowledged that the resident's SDM was not notified within 12 hours upon becoming aware of the verbal abuse however they had called the SDM after their investigation was completed. [s. 97. (1) (b)]

2. A CIS was submitted to the MOHLTC that described an incident of staff to resident neglect. The CIS documented that an identified staff member failed to provide specific care to an identified resident on a specific date.

The home's investigation records stated that the resident was found with the specific care not provided. The progress notes in PCC showed that the resident sustained altered skin integrity as a result of the incident and was referred to the Physician for further treatment.

During an interview on a specific date the DOC stated that they were not aware of the injury because they had not reviewed the progress notes to determine if any injuries were sustained to the resident. They acknowledged that the SDM of the resident was not notified of the incident.

The licensee failed to ensure that two residents SDM's and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker and any other person specified by the resident is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. The area or location of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, any staff members or other persons who were present at or discovered the incident, and names of staff members who responded to the incident. 3. Actions taken in response to the incident, including, what care was given as a result of the incident, and by whom. 4. Analysis and follow-up action, including the long-term actions planned to correct the situation and prevent recurrence.

A CIS was submitted by the previous DOC on a specific date. This CIS stated that an incident of alleged abuse of a resident occurred on a specific date by an unknown staff member. The CIS did not include a description of the individuals involved in the incident, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or were responding to the incident, what care was given as a result of the incident and by whom and the long-term actions planned to correct the situation and prevent recurrence.

There were no investigation records or incident documentation in the residents plan of care in PointClickCare (PCC). There was no incident documentation in Risk Management.

In an interview with the current DOC on a specific date they said that they were unable to locate any documentation other than the CIS and this included investigation records, PCC and risk management documentation. The DOC reviewed the home’s employee files and stated that they were unable to determine the staff member involved.

The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, to include a description of the individuals involved in the incident, including, any staff members or other persons who were present at or discovered the incident, and names of staff members who responded to the incident, the actions taken in response to the incident, including, what care was given as a result of the incident, and by whom and an analysis and follow-up action, including the long-term actions planned to correct the situation and prevent recurrence. [s. 104. (1)]

Issued on this 22nd day of March, 2018

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) :	SHERRI COOK (633), APRIL TOLENTINO (218), INA REYNOLDS (524), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_610633_0002
Log No. / No de registre :	001736-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 19, 2018
Licensee / Titulaire de permis :	Golden Years Nursing Homes (Cambridge) Inc. 704 Eagle Street North, P.O. Box 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	Golden Years Nursing Home 704 Eagle Street North, P.O. Box 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Danny Pereira

To Golden Years Nursing Homes (Cambridge) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_600568_0007, CO #001;

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 must be compliant with s. 19(1) of the LTCHA.
Specifically the licensee must:
a) Ensure that two specific residents, and any other resident, are protected from abuse by anyone.
b) Ensure that six specific residents, and any other resident, are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to comply with order #001 from Resident Quality Inspection (RQI), 2017_600568_0007 served on June 7, 2017, with a compliance date of August 31, 2017.

The licensee was ordered to ensure:

a) That all residents are protected from sexual abuse by anyone.
b) That all staff in the home are aware of what constitutes sexual abuse of a resident, and that staff are provided education / training related to it's definition, consent for both cognitive and non-cognitive residents, and the staff's responsibility should they witness or suspect sexual abuse.

The licensee completed a) and b) in CO #001.

The licensee failed to comply with 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.

Specifically, nine resident's were not protected from abuse or neglect after the compliance date of August 31, 2017.

1. The licensee has failed to ensure that residents were protected from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) that identified an incident of staff to resident abuse which occurred on a specific date. The CIS report stated that there were two staff witnesses.

The plan of care in PointClickCare (PCC) stated that the identified resident had a Cognitive Performance Score (CPS) which indicated a moderate cognitive impairment. The care plan dated on a specific date stated that there were specific interventions in place when the resident was demonstrating specific behaviours.

During an interview on a specific date, two staff members said that they witnessed the incident. One staff member also said that they were bothered by what they saw and they reported the incident to their Manager. The other staff member said that they observed the resident demonstrating behaviours and the resident also appeared afraid.

During an interview on a specific date with the identified staff member involved they said that the resident was demonstrating behaviours and they did not recall that abuse occurred. The employee file for the identified staff member and the home's investigation records stated that a disciplinary action was taken related to this incident.

During an interview on a specific date with the Director of Care (DOC) and the Assistant Director of Care (ADOC) they acknowledged that abuse did take place by the identified staff member towards the identified resident.

The licensee has failed to ensure that an identified resident was protected from abuse by an identified staff member on a specific date. [532]

2. Ontario Regulation 79/10 defines neglect as, “the failure to provide a resident

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

The home's “Definitions of Abuse 005010.00a” dated May 2016, defined neglect as stated above.

A CIS was submitted to the MOHLTC that stated that an identified staff member failed to provide specific care to six residents on a specific shift and date.

The home's investigation records documented the condition that the six residents were found in on the next shift.

Written statements related to the incident, that were completed and signed by oncoming staff members, stated that they had found the six identified resident's in the condition as described in the home's investigation records.

The Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) Assessments previous to the incident related to specific care and the care plans in PCC stated that the six identified residents all required specific interventions and assistance from staff. The care plans also documented that four residents were considered at risk for impaired skin integrity.

The progress notes in PCC stated that one identified resident sustained altered skin integrity as a result of the incident and they were referred to the Physician for further treatment. There was no further documentation in PCC for the other five residents.

Resident interviews were attempted on a specific date. Four residents were not interviewable and two residents were discharged from the home for reasons unrelated to this incident.

During staff interviews on a specific date four staff members corroborated the incident. One staff member stated that there had been previous incidents of a similar nature involving the same identified staff member. The four staff members agreed that not providing a specific care for a resident was a form of neglect.

During an interview on a specific date with the identified PSW they

acknowledged that they did not provide a specific care for three identified residents. They explained that they were too busy performing a housekeeping task and they understood that resident care should have been the priority. The staff member also said that they failed to document and report the conditions in which they left the residents to the oncoming staff.

During an interview on a specific date with the DOC and ADOC, the DOC stated that they considered no documentation of resident care as care not provided. The DOC also stated that they had no tolerance for abuse or neglect at the home and both the DOC and the ADOC considered this incident as staff neglect towards the six identified residents. The identified staff member received an unpaid suspension related to this incident.

The licensee failed to ensure that six residents were not neglected by an identified staff member on a specific date. [218]

3. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A CIS stated that on a specific date an identified resident reported that a staff member caused them a specific injury. The CIS further stated that the resident was receiving a specific intervention and their cognition was intact. The CIS also stated that the resident was not able to provide details regarding the staff member involved.

A photo in PCC on a specific date showed a specific injury to the resident. The plan of care in PCC stated that the identified resident had specific diagnoses and their cognition was borderline intact. A progress note in PCC on a specific date for the identified resident stated their account of the incident and that the Manager on call was notified of the incident by staff.

The home's investigation notes included a summary of the incident dated on a specific date by the DOC and they indicated that they interviewed staff and no disciplinary action was taken. The DOC also identified in their report that the resident required assistance from staff for specific care and that the resident was unable to describe anything about any of the people who allegedly were in the room despite knowing regular staff by name. Staff who were working that day were questioned by the DOC and denied being a part of or witnessing the incident. The DOC also stated that the resident had a specific device and it was

possible that they were injured by this intervention.

During an interview on a specific date with the identified resident they restated repeatedly their account of the incident and demonstrated how the staff member injured them. The resident also stated that they communicated the incident with staff members. They resident expressed again that it was two staff members present and it was one of the staff members that injured them. The resident also shared that staff were redirected since this incident as they were now assisting them differently. The resident reiterated that it was painful initially and then the pain went away.

During an interview on a specific date a staff member shared that they did not provide care to the identified resident as the resident had refused. The staff member said that the resident told them about the incident and showed them their injury. The staff member explained that the resident also said to them that they had said "ouch". The resident also stated that the incident happened between a specific time period. The staff member agreed that there was an injury to the resident and they had reported this to the registered staff.

During an interview on a specific date a staff member said that the resident showed them their injury the next day and told them that staff did it. The staff member said that they were shocked by the injury as it was quite extensive. They also said that the resident was competent and knew the staff but the resident did not know all of the staff by their names.

During interviews on a specific date two staff members shared that staff had reported the incident to them. The staff members said that the resident reported that the incident occurred during care and they were injured then. The resident also said that there were two staff members present in the room. The staff member stated that there was no description provided by the resident of the staff involved and they had informed the Registered Nurse (RN) right away. The RN explained that the resident showed them their injury and they had thought that it looked new to them. The RN also said that they completed an assessment, documented everything that the resident had told them and notified the on call Manager. The RN also said that they interviewed staff and they did not know about the incident. The RN shared that the resident had not injured themselves in the past in anyway.

During an interview with the Director of Environmental and Food Services

(DEFS) on a specific date, they said that they were on call at the time of the incident and they had informed the DOC right away by text from their personal phone. The DEFS showed the text to the Inspector and it stated that the resident was upset that two staff had provided them care and one had injured them. The DOC responded by text and stated "ok thanks….will look into it tomorrow".

During an interview on a specific date the DOC said that the resident was on a specific intervention and their skin was thin. The DOC also stated that it was not until they looked into this incident further that they realized that it was an allegation of abuse. The DOC explained that when they spoke to the resident they were almost dismissive of them and they had told them that there were three staff members present and they would not give them the names of the staff involved. The resident told the DOC that they would have said “ouch”. The DOC also said that they reproached the resident on another date to ask the resident again about the details of the incident. The DOC explained that the resident repeated the same account of the incident. The DOC stated that they only interviewed and questioned the staff who cared for the resident that day. The DOC said that they had determined that no staff were identified as having a role in this injury to the resident and therefore no disciplinary action was taken. The DOC acknowledged that they did not interview all staff. The DOC said that they thought that the injury to the resident was potentially caused by their device and had spoken to the Occupational Therapist (OT) regarding this device.

During another interview on a specific date with the identified resident regarding the incident they relayed the same account of events at least three times to the Inspector. When the resident was asked if there was a possibility that their injury was related to their device the resident was adamant that they did not injure themselves with their device. The resident was able to demonstrate how they were able to use their device. The resident was upset that their device was even suggested as a potential cause of their injury and again they repeated and verified that staff had caused their injury.

The People Care policy "Abuse/Neglect Employee 004060.00", not dated, stated “signs and symptoms that a resident has been or was being abused included unexplained physical injury.”

During an interview with the DOC on a specific date they said that they were misinformed by staff related to this incident as they were told that the resident was injured related to repositioning. The DOC explained that it was not

communicated to them by staff that there was an allegation of abuse.

The licensee has failed to ensure that an identified resident was protected from abuse by anyone. [532]

4. Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A CIS related to the alleged abuse of an identified resident was submitted to the MOHLTC by the DOC on a specific date. The CIS stated that the resident sustained specific injuries that were related to possible neglect and physical abuse. The CIS further stated that the resident experienced increased pain and decreased mobility as a result of their injury.

The photos in PointClickCare (PCC) for the identified resident that were taken on specific dates showed extensive injuries. The plan of care in PCC stated that the resident required total assistance for care and mobility and two staff with a specific device for transfers for specific care. The progress notes in PCC documented the incident and the resident's injuries over time on specific dates.

During an interview with the identified staff member they said that they were assisting the resident alone while providing a specific care on a specific date and the resident was injured. The staff member agreed that they were using the incorrect device and they also acknowledged that the resident required two persons for the transfer for this specific care. The staff member denied that the injury of the identified resident was a result of their transfer with the incorrect device. They also said that they had reported the incident to the Charge Nurse.

During an interview with a staff member they said that they answered the call bell for the identified resident on a specific date and they witnessed the resident in the incorrect position and transfer device. The staff member also said that the staff member was assisting the resident alone. The staff member stated that they did not report their account of the incident to the registered staff as they had told the identified staff member to do so. The staff member stated that when they returned to work five days later the resident looked worse. They also said that they had thought that something else could have occurred and wondered if the incorrect device had been used again. They agreed that it was not until five days

later that they told the DOC of their account of the incident that occurred on a specific date.

During an interview with a registered staff member on a specific date they said that they were the Charge Nurse when the incident occurred. They explained that the two staff members did not report to them the details of the incident that included the use of the incorrect transfer device by only one staff member. They also stated that they noticed that the resident had altered skin integrity on a specific area and they did not complete a head to toe assessment of the resident for other injuries as they did not know to do so. The registered staff member also said that they reported the limited information that they knew to the Vice President of Clinical Services (VP) and were told to initiate a specific intervention. They agreed that an unsafe transfer that resulted in the resident's significant injury would be considered improper care and incompetent treatment of a resident.

During an interview with a staff member on a specific date they said that they they provided care to the identified resident at a specific time and date. They explained that they saw the residents injury and were alarmed and scared with what they saw. They also said that they reported their concern to the registered staff immediately. The staff member also stated that they had witnessed the resident's injury again at a specific time and date and they had reported to the same registered staff again of their concern that the injury of the resident had become much worse. They denied suspecting that abuse of the resident had or may have occurred however, they did state that they wondered if the incorrect device was being used to transfer the resident or if the resident had fallen.

During an interview with the registered staff member they said that they worked on three specific dates and they were aware from shift report that the resident had an incident. They also stated that they were informed of the injury of the identified resident by staff on a specific date and they had referred to the resident's chart, confirmed the incident and noted that the resident was not receiving a specific intervention and was not a falls risk due to their lack of independent mobility. They said that they observed the injury, however they did not asses the resident's injuries fully or take photos as the resident had been recently dressed by the staff. The registered staff member said that it was not until two days later that they removed the incorrect transfer device from the resident's room and documented in PCC for staff to use a specific device for all transfers. They explained that it was not until a specific date that they assessed

the injury and took photos. They stated that they did not report the injury and condition of the identified resident to the Manager on call and they agreed that they should have. They reviewed the plan of care for the resident in PCC and they were unable to locate a completed specific assessment. They explained that they recalled completing a paper assessment however the assessment was incorrectly entered into PCC and staff were not prompted to complete this task. They agreed that an improper transfer that resulted in the injury sustained to the resident would be considered incompetent treatment and care of a resident.

During an interview with a staff member on a specific date they said that they worked a specific shift and recalled the injury on the identified resident. They also said that they were unaware of the incident that had occurred. They agreed that the resident had not had an injury like that in the past and they agreed that abuse may have occurred. The staff member explained that they did not report the resident's injury or their concern to Management as they had understood that staff had already reported to them.

During an interview with the DEFS on a specific date they said that there were on call on specific dates and they were unaware of the incident related to the identified resident that occurred on a specific date, or the significant injury that developed on the three days after. When they were shown the photos of the injury they said that an unsafe transfer that resulted in the injury to the identified resident was incompetent treatment of a resident and the expectation would be that staff reported both the incident and the injury to Management on call when after hours.

During interviews with the VP, Administrator, DOC and ADOC on specific dates they all said that no staff had reported the details of the incident that included the unsafe transfer of the resident, however the VP and DOC did state that they were aware that the resident had an incident and may have hit their specific body part. They all also said that they were not unaware of the injury which developed over the next days. The DOC explained that they returned to work and they observed the injury of the resident then and they had determined that the origin of the residents injury was an unknown cause and not alleged or potential abuse. The DOC explained that it was not until the next day, five days later, when a staff reported to them that the resident had an incident with their device that they had determined that an unsafe transfer had occurred by the identified staff member that had resulted in the significant injury of the resident. The VP and DOC both agreed that the resident required a specific transfer

device with two staff assistance as the resident was unable to hold their own weight. They also said that the staff member did not follow the plan of care for this resident and an unsafe transfer had occurred. They also stated that the injury to the resident did not just suddenly appear and that many staff were aware and had not reported to them. The VP also said that they advised the RN to initiate a specific assessment. The VP stated that after the initial assessment, they were unable to locate a completed paper assessment in the resident's chart or a summary progress note in PCC. The VP explained that the expectation was that the assessment be completed for 72 hours and this was not completed and should have been.

The People Care policy "Abuse/Neglect Employee 004060.00", not dated, stated "signs and symptoms that a resident has been or was being abused included unexplained physical injury."

The home's policy "Nursing-Zero Lift and Transfer Program 007020.00" stated that:
-"All staff will follow the required lift procedure outlined on the care plan/bedside logo of each resident at all times.
-All staff are responsible to report any unsafe acts.
-Two staff must be in constant attendance for all lifts/transfers
-Staff cannot make the decision to decrease the amount of assistance required for a transfer until the resident was assessed by a physiotherapist.
-For a mechanical lift and Sit/Stand lift two caregivers must be present during the lifting procedure."

The employee file for the identified staff member included a written notification letter that stated that they did not follow the plan of care for the resident related to their transfer device and level of assistance required for specific care. The VP and the identified staff member both confirmed that the staff member no longer worked at the home.

The licensee has failed to ensure that an identified resident was provided with the treatment, care, services or assistance required for health, safety or well-being, that included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to nine

of 13 residents reviewed. The home had a level 5 history as they had ongoing non-compliance with this section and related sections of the LTCHA that included:
• voluntary plan of correction (VPC) related to s.24(1) issued February 6, 2015 (2015_228172_0006);
• compliance order (CO) #003 issued June 7, 2017 made under s. 24(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• compliance order (CO) #001 issued June 7, 2017 made under 19(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• written notification (WN) related to 19(1) issued October 30, 2017 (2017_601532_0010). [633] [532] (218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_600568_0007, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24(1) of the LTCHA.
Specifically the licensee must:
a) Ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Grounds / Motifs :

1. The licensee has failed to comply with order #003 from Resident Quality Inspection (RQI), 2017_600568_0007 served on June 7, 2017, with a compliance date of August 31, 2017.

The licensee was ordered to:

Ensure that the person(s) who had reasonable grounds to suspect that abuse of a resident by anyone may have occurred, immediately reported the suspicion

and the information upon which it was based to the Director.

The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) that a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Specifically, five incidents related to improper or incompetent treatment or care of a resident and alleged abuse/neglect of a resident occurred after the compliance date and were not submitted by the home to the Director immediately as required.

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

1. A CIS was submitted to the MOHLTC on a specific date and time that was related to an incident of alleged resident to resident abuse. The CIS stated that the identified resident received an injury as a result of an incident.

The home's People Care policy "Abuse or Suspected Abuse/Neglect of a Resident" 005010.00, not dated stated the following in part:
-"That all staff have an obligation to report any incident or suspected incident of resident abuse.
-Employees who fail to report any incidents or concerns shall be disciplined.
-Employee was to notify the charge nurse.
-Charge Nurse were to notify the RN and notify the DOC/ED immediately.
-That the ED or designate would notify the Director immediately".

In an interview with the DOC on a specific date they stated that management were not aware of the incident until the next day at the morning huddle with the multidisciplinary team. The DOC said that the expectation for staff related to reporting alleged abuse was that the RPN would report to the Charge Nurse and the the Charge Nurse was to immediately report the incident to Management.

The DOC said that Management would then immediately call in the CIS if after hours or complete the CIS Report online if during business hours. The DOC agreed that this process had not been followed by staff and this incident was not reported to the Director immediately as required and should have been.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of an identified resident by anyone that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

2. A CIS was submitted to the MOHLTC that identified a staff to resident abuse that occurred on a specific date. The CIS was not submitted to the Director immediately. The CIS further stated that there were two staff witnesses and the situation had escalated.

The home's investigation records stated that the incident occurred on a specific date and the two staff witnesses did not report the incident immediately to the Charge Nurse. The incident was reported to ADOC the next day and the DOC did not report to the Director until six days later.

During interviews on specific dates the two staff members shared that they witnessed the incident and agreed that they did not report the incident to their Manager until the next day and they did not complete a CIS to the Director immediately.

During an interview on a specific date the ADOC shared that they became aware of the incident the next day. The ADOC said that both staff were asked by them to provide a written statement which went to the DOC however the DOC was away at the time. The ADOC also said that in retrospection, they should have investigated the incident immediately but being new to their role and learning they did not realize at the time to immediately investigate and report to the Director as required.

During an interview on a specific date the DOC shared that they had re-educated all their staff in relation to abuse. The DOC stated that there was a trend or culture of complacency in the home related to staff not reporting alleged abuse to Management. The DOC acknowledged that they did not notify the Director immediately as they were under the impression that they could gather the information and complete the investigation before notifying the Director. The

DOC said that they now knew that they were to immediately report incidents of abuse to the Director as required.

The licensee failed to immediately report the alleged abuse of and identified resident by an identified staff member and the information upon which it was based to the Director. [s. 24. (1)]

3. A CIS related to the alleged abuse of an identified resident was submitted to the MOHLTC by the DOC four days after the incident of alleged abuse occurred. The CIS stated that the resident sustained injuries related to possible neglect and physical abuse on a specific date, and the resident experienced increase pain and decreased mobility as a result of their injury.

During an interview with the identified staff member on a specific date they said that they did not provide the resident the level of assistance required for a specific care and they were also using the incorrect device. The staff member also said that they reported the incident to the Charge Nurse and they did not complete mandatory reporting to the Director as their role was to report the incident to the registered staff.

During an interview with a staff member on a specific date they said that they witnessed the resident in the incorrect position and device. They also said that the level of assistance required for a specific care was not provided to the resident. The staff member stated that they did not report the incident to the registered staff as they had told the identified staff member to do so. They also said that they did not complete mandatory CIS reports to the Director and they were unsure of who did.

During an interview with a staff member on a specific date they said that they were working the a specific shift and had provided the resident care at a specific time. They explained that they saw the injury and had immediately informed the Charge Nurse who came and also witnessed the residents injury. The staff member stated that they did not complete mandatory reporting to the Director as their role was to inform the registered staff.

During an interview with a registered staff member on a specific date they said that they worked on specific dates and were aware from shift report that an incident occurred. They also stated that they were informed of the residents injury at two separate times and they did not call the Manager on call. They also

acknowledged that they should have informed Management and they did not. They also said that they did not report to the Director as this this was the role and at the discretion of Management.

During an interview with a staff member on a specific date they said that they worked a specific shift and date and recalled the injury of the identified resident. The staff member explained that they did not report the resident's injury or their concern to Management as they had understood that staff had already reported to them. They also did not report to the Director as they said this was the role of Management.

During an interview with the DEFS on a specific date they said that they were on call on specific dates and they were unaware of the incident and injury related to the identified resident. They said that the expectation was for staff to call them when after hours as they were on call. They further stated that they would contact the Administrator or the DOC to complete the CIS report to the Director as required as they were not a nurse.

During interviews with the Administrator, DOC and ADOC on specific dates they all said that no staff had reported the full details of the incident to them however the DOC did state that they were aware that an incident had occurred. They all also said that they were unaware of the injury that occurred in the three days after the incident. The DOC explained that they witnessed the significant injury and had determined the origin of the residents injury as "unknown cause" and not alleged or potential abuse and therefore they did not complete a mandatory CIS to the Director immediately as required. The DOC acknowledged that they did not report to the Director until five days after the incident occurred.

During an interview with the the VP and the DOC on a specific date they explained that the process in the home for reporting incompetent treatment/alleged abuse was that the PSW's reported to the registered staff and the Charge RN would report to the DOC if during business hours or staff were to call the on call Manager if after hours. They also said that the expectation related to reporting to the Director was immediately. The DOC said that the process in the home for reporting to the Director was that they, the Administrator and possibly the ADOC completed all the mandatory reporting to the Director. The VP explained that there was an on-going culture in the home of staff not reporting to Management despite the education that had been provided to all staff by the home. The VP, DOC and ADOC all said that staff should have

reported to them and they did not.

The policy "Abuse/Neglect Employee 004060.00", not dated stated that signs and symptoms that a resident had been or was being abused included "unexplained physical injury". Under the sub heading "Prevention" it was stated that "5. Employees are to report all injuries whether the cause is known or unknown". The policy further stated that the "nurse manager will immediately advise the ED and DOC upon receiving a report of suspected abuse".

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the improper or incompetent treatment or care of and identified resident that resulted in harm or a risk of harm to the resident was immediately reported with the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

4. A CIS was submitted to the MOHLTC on a specific date and stated that an incident of alleged staff to resident abuse occurred on a specific date. The CIS further stated that an identified resident reported that staff caused them an injury.

The progress notes in PCC on a specific date stated that the resident reported to a specific staff member that they were injured as a result from a staff member while providing personal care. This note also documented that the Manager on call was informed. The staff member did not report to the Director as required.

During an interview on a specific date with the DEFS they shared that the registered staff member had notified them regarding the incident. They said that they had informed the DOC by text and they were told by the DOC by text that they would look into it the next day. They also said that the expectation was to call the MOHLTC after hour number immediately however they did not call or submit a CIS report to the Director as required.

During an interview on a specific date the DOC was asked about the late report to the Director once they were aware of the alleged abuse incident. The DOC replied that when they received the phone call from the DEFS they were

misinformed concerning the incident. The DOC acknowledged that the reporting of the alleged abuse to the Director was late. The DOC also said that it was their understanding to collect the information related to abuse, start the investigation and then submit the CIS to the Director. The DOC further stated that they now understood that they were to immediately report incidents of abuse to the Director as required.

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the improper or incompetent treatment or care of an identified resident that resulted in harm or a risk of harm to the resident was immediately reported with the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

5. A CIS was submitted to the MOHLTC five days after a staff member witnessed an incident of rough care towards an identified resident by an identified staff member on a specific date. The CIS stated that the resident was upset.

During an interview with the DOC on a specific date they stated that a staff member reported the allegation to them five days after the alleged incident. The DOC also said that they started the investigation, looked into the allegations and reported the information to the Director when they became aware of the alleged abuse. The incident was not reported immediately to the Director by the staff member as required.

The licensee failed to immediately report the alleged abuse of and identified resident by an identified staff member and the information upon which it was based to the Director. [s. 24. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to nine of 13 residents reviewed. The home had a level 5 history as they had ongoing non-compliance with this section and related sections of the LTCHA that included:
• voluntary plan of correction (VPC) related to s.24(1) issued February 6, 2015

(2015_228172_0006);
• compliance order (CO) #003 issued June 7, 2017 made under s. 24(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• compliance order (CO) #001 issued June 7, 2017 made under 19(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• written notification (WN) related to 19(1) issued October 30, 2017 (2017_601532_0010). [633] [218] [524] (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Order / Ordre :

The licensee must be compliant with s. 20 (1)(2).
Specifically the licensee must:
a) Ensure that the policy to promote zero tolerance is complied with including the process for completing and documenting investigations.
b) Revise the policy to promote zero tolerance to ensure compliance with s. 20(2) of the LTCHA which includes the duty to report under s. 24(1) of the LTCHA.
c) Re-educate all staff and Management on the revised policy to promote zero tolerance including the process for completing and documenting investigations and the duty to report under s. 24(1) of the LTCHA. This training must be documented.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20(1) and s. 20(2) of the LTCHA.

In accordance with s. 20(1), the licensee was required to ensure that the policy to promote zero tolerance was complied with.

In accordance with s. 20(2), the licensee was required to ensure that policy to promote zero tolerance contained the duty to report under s. 24(1) of the LTCHA.

Specifically:
-Five incidents related to alleged abuse of resident's were not submitted to the Director immediately.
-Two incidents of alleged abuse were not investigated immediately.
-Four of the home's investigation records were incomplete and inconsistently documented.

-The home's abuse policies did not contain the duty to report under section 24 of the LTCHA Act.

LTCA 2007, c. 8, s. 20 (1) states that "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."

1. LTCA 2007, c. 8, s. 20 (1) states that "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."

The home's People Care policy "Abuse or Suspected Abuse/Neglect of a Resident" 005010.00, not dated stated the following in part:
-"That all staff have an obligation to report any incident or suspected incident of resident abuse.
-Employees who fail to report any incidents or concerns shall be disciplined.
-Employee was to notify the charge nurse.
-Charge Nurse were to notify the RN and notify the DOC/ED immediately.
-Investigation was to begin immediately.
-That the ED or designate would notify the Director immediately
-That the Charge RN would obtain written statements from all witnesses and document account of the incident using the Incident Report Form
-It was recommended that the RN initiate the "Nursing Checklist for reporting/investigation" alleged abuse of a resident.
-Attachment 005010.00 (b) “Nursing Checklist for Reporting and Investigating Alleged Abuse”.

The home's policy “Mandatory/Critical Incidents 003400.00” stated in part that:
-"It is the policy of peopleCare to document and report all incidents.
-Utilize the Decision Trees as a tool to guide decision-making about the need to notify the Director or handle as an internal investigation. Document answers to questions in Decision Tree and file as part of the investigation".

The home's Abuse Program annual evaluation dated April 2017, stated in part that:
-When completing an investigation use the “Investigation Report" for documentation.

-There was a recommendation documented to include a statement in the Abuse policy that during an investigation "record on the investigation report all the details" and "highlight the form on the policy for easy retrieval".
The 2017 Abuse Program evaluation stated that this change was made on May 16, 2017.

On two specific dates the DOC explained the education to staff related to alleged abuse and mandatory reporting and they showed inspectors the poster board "Learn to Recognize a Critical Incident, Golden Years CI Defined". The poster contained decision trees for abuse, a nursing checklist for reporting/investigating alleged abuse of a resident, a Critical Incident (CI) policy, a Mandatory CI report checklist that included abuse/neglect mandatory report, the after-hours contact for the Manager on call and timelines for reporting.

1. A CIS was submitted to the MOHLTC that described an incident of neglect by a staff member towards multiple residents. The investigation records included statements obtained from staff by the DOC that were handwritten and an interview completed with the accused staff member that was documented electronically using a Microsoft Word Document. The home's investigation records did not include a "Nursing Checklist, Incident Report Form" initiated by an RN per the home's policy to document the written statements obtained from the witnesses involved at the time of the incident and an "Investigation Report" to document the investigation was not included.

During an interview with the DOC on a specific date they stated that their investigation notes were captured and described in the CIS report submitted to the Director. [218]

2. A CIS identified a staff to resident abuse that occurred on a specific date. The home's investigation records did not include statements from two staff at the time of the incident and their statements were taken after an interview with the DOC. The RN in charge did not obtain written statements from witnesses and document the staff account of the incident using the "Incident Report Form". A "Nursing Checklist" was not included in the home's investigation records, an "Investigation Report" for documenting investigations was not present and answers to questions in the Decision Tree were not filed as part of the investigation.

During an interview with a registered staff member they indicated that they were

not interviewed as part of the investigation and did not provide a written statement.

During an interview with the Administrator and DOC on a specific date they both said that there was no further documentation related to this incident involving the identified resident.

In an interview on a specific date the ADOC acknowledged that they were new to the role and were learning the process for investigating alleged abuse. [532]

3. A CIS stated that an identified resident reported that a staff member had caused them an injury on a specific date.

The home's investigation records did not include a written statement from four staff members. Statements from two staff were completed after interviews with the DOC. The RN in charge did not obtain written statements from all staff at the time of the incident nor did they document their account of the incident using the "Incident Report Form". A "Nursing Checklist", an "Investigation Report" for documenting investigations and answers to questions in the Decision Tree were not filed as part of the home's investigation.

During an interview with a registered staff member they indicated that they were not interviewed as part of the investigation and did not provide a written statement.

During an interview with the Administrator and DOC on a specific date they both said that there was no further documentation related to the incident involving the identified resident.

4. A CIS related to alleged abuse of an identified resident was submitted to the MOHLTC by the DOC on a specific date. The CIS stated that the resident sustained significant injuries after a staff member was assisting them alone on a specific date.

The investigation records only included statements from staff after interviews with the DOC and many of these statements were not dated. The home's investigation records did not include statements obtained from the Charge Nurse that were documented on an "Incident Report Form", a "Nursing Checklist" was not included and an "Investigation Report" for documenting investigations was

not completed.

During an interview with the Administrator and DOC on a specific date they both said that there was no other further documentation related to the incident involving the identified resident.The DOC agreed that a "Nursing Checklist, CI Mandatory Report Form or Incident Report Form" as stated in the home's Abuse policy were not completed related to the incident involving this resident and answers to questions in the Decision Tree were no filed as part of the home's investigation.

During an interview with a registered staff member they said that they do not do investigations, take statements or complete a nursing checklist. They also said that RN's do not complete this documentation either. They said that they would complete an internal complainant form and leave it for the DOC. They agreed that they had been provided training related to abuse by use of a poster board that contained the "Nursing Checklist" and a "Mandatory CI Report Checklist".

During interviews with two RN's on specific dates they both said that they did not complete abuse investigations and related documentation as their role was to report the incident/allegation to the DOC.

During an interview with the ADOC on a specific date they stated that the documentation related to alleged abuse investigations included the "Nursing Checklist" and did not include the "Investigation Form" or the "CI Report Checklist". The ADOC explained that their understanding was that they could look at the checklists and could choose which one was relevant and this would be the documentation completed for alleged abuse investigations.

During an interview with the Administrator and DOC on a specific date, who reviewed the education board posted in the private dining room, the DOC agreed that staff had been provided education with this tool and the poster board was available for the staff for continued access. This board contained the "Nursing Checklist" and the "Mandatory CI Report Form" and did not include the "Investigation Report Form". The DOC shared that she was not aware of the "Nursing Checklist" and said that the staff were not completing them. The DOC also stated that they thought that the "Mandatory Critical Incident (CI) Report" and "Nursing Checklist" were the same.

During the exit debrief of the home on a specific date the VP stated that the

expectation for documentation related to abuse investigations was to follow the abuse policy. The VP also said that they understood that the "Nursing Checklist, Critical Incident Report Form and the Incident Report Form" were tools that staff could use and they would change the policy so that staff may use these forms or not. The VP also agreed to review the home's Abuse policy and associated forms/checklists to determine the documentation required in the home related to alleged abuse reporting and investigations.

2. LTCHA 2007, c. 8, s. 20 (2) states in part that "at a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(d) shall contain an explanation of the duty under section 24 to make mandatory reports".

LTCHA 2007, c. 8, s. 24 (1) states in part that "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

Three policies related to abuse or alleged abuse/neglect of a resident and mandatory reporting to the Director were provided by the DOC and Administrator. They both stated that these abuse policies were currently used in the home. The home's policies "Abuse or Suspected Abuse/Neglect of a Resident 005010.00", "Abuse and Neglect (Employee) 004060.00 and "Mandatory/Critical Incidents 003400.00", that were not dated, did not contain an explanation of the duty under section 24 to make mandatory reports.

During interviews on specific dates with four Personal Support Workers (PSW's) and two Registered Practical Nurses (RPN's) all said that they did not complete Critical Incident System (CIS) Reports or call the after-hours pager to report alleged abuse incidents to the Director as their role was to report to the Charge Nurse. One PSW said that they did not know who completed CIS reports. Two Registered Nurses (RN's) both said that Management looked after the reporting to the Director and they did not compete CIS reports or call the after-hours pager. Both RN's also said that they would call the on call Manager if the

incident occurred after-hours.

During an Interview with the DEFS on a specific date they said that at times they were the on call Manager on the weekends and if a staff member called them to report alleged abuse they would call or email the DOC or Administrator. They also said they did not complete CIS reports.

The most recent annual Abuse Program evaluation dated April 2017 stated that there was a "concern with staff reporting to manager on call thereby missing the reporting time frames for the Director".

During an interview with Vice President of Clinical Services (VP) and DOC on a specific date they said that the expectation for staff related to reporting alleged abuse was to inform their Manager immediately if they were present at the home or staff were to call the Manager on call if the incident was after hours. They also said that the expectation of the home was that all alleged abuse was reported to the Director immediately and this was completed by Management who completed the CIS Reports to the MOHLTC. The VP explained that there were on-going issues related to staff not reporting allegations of abuse of a resident to Management immediately.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports to the Director. [s. 20.]

The severity of this issue was determined to be a level 2 Minimal Harm/Risk or Potential for Actual Harm/Risk. The scope of the issue was a level 2 as it related to 4 of 8 Critical Incidents reviewed. The home had a level 3 history as they had ongoing non-compliance with related sections of the LTCHA that included:
• voluntary plan of correction (VPC) related to s.24(1) issued February 6, 2015 (2015_228172_0006);
• compliance order (CO) #003 issued June 7, 2017 made under s. 24(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• compliance order (CO) #001 issued June 7, 2017 made under 19(1) with a compliance due date of August 31, 2017 (2017_600568_0007);
• written notification (WN) related to 19(1) issued October 30, 2017 (2017_601532_0010).

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 19th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

Service Area Office /
Bureau régional de services : Central West Service Area Office