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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2015	2015_291552_0019	O-002388-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

MARIA FRANCIS-ALLEN (552), JOANNE HENRIE (550), KATHLEEN SMID (161), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 13 -17, July 20-23, 2015

Also inspected during the Resident Quality Inspection:
Follow up inspection Log # O-001758-15, Critical Incident Log # O-001568-15, O-001685-15, O-001920-15, O-002052-15, O-002136-15, O-002252-15, O-002332-15 and O-002478-15 were inspected concurrently

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident Care Coordinators, Administrative Assistant, Environmental Manager, RAI Coordinator, Acting Manager of Nursing Practice, Infection Control Nurse, Occupational Therapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), members of the Behavioural Support Team (BSO), President of the Resident Council and Family Council, family members and residents.

The inspectors also toured the home, observed interactions between staff and residents during the provision of care, dining and snack services, administration of medication, reviewed clinical health records and the licensee's policies: Abuse, Minizing of Restraints, Falls Prevention, Medication, Family and Resident Council minutes

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

* assessment
* reassessments
* interventions, and
* documentation of the resident's responses to the interventions

Regarding Resident #047 (related to log # 002052 & # 001920):

Review of the progress notes for Resident #047 indicated that on 5 identified dates, the resident was witnessed demonstrating sexually inappropriate responsive behavior towards Resident #001, #048 and 3 unidentified co-residents.

Review of health record for Resident #047 indicated:
-the resident was on every 15 minute checks for approximately 2 weeks
-the resident was on hourly checks for approximately 2 weeks
-the resident was on DOS (hourly dementia observation system) for approximately 3 weeks (with several blank entries).
-the BAT (behavioural assessment tool) indicated the resident demonstrating sexually inappropriate responsive behavior. No triggers were identified. The interventions included: relocation to another unit, every 15 minute checks, medication , DOS tool,

specimen collection , and every 30 minute checks to commence after the medication is increased to higher recommended dose.
- a tip sheet both provided strategies to manage the sexually inappropriate responsive behavior.

- a consultation report from Ontario Shores provided recommendations that included: OT to complete a sensory assessment, enhancing opportunities for tactile stimulation), meaningful activities to reduce inappropriate behaviours(Montessori type activities as resident needs to have busy work).

The behavioural triggers were not identified for Resident #047 who demonstrated sexually inappropriate responsive behavior towards co-residents. Strategies were not developed and implemented for Resident #047 until after the third incident of sexually inappropriate responsive behaviour and strategies identified by Ontario Shores were not implemented until after the behaviours discontinued. [s. 53. (4)]

2. Regarding Resident #046 (Related to Log # 001568):

Review of the progress notes for Resident #046 indicated:
- the resident was admitted to the home on an identified date and was cognitively impaired
-over an 11 day period, the resident demonstrated(physical) sexually inappropriate responsive behaviours 9 times towards Residents' # 001, #045 and other unidentified co-residents. Staff interventions included : removing the resident from the area, referring the resident to the BSO team, completion of DOS (on one occasion) and completion of the PIECES assessment. The police was notified on 1 occasion.The resident also demonstrated (both verbal and physical) sexually inappropriate behaviors towards staff members.
- over this time frame, the physician was notified three times of these behaviours and medication was ordered on one occasion and dosage reviewed on another occasion.

Review of the care plan for Resident #046 indicated the resident was cognitively impaired and exhibited responsive behaviours of: wandering and inappropriate sexual behaviour. Interventions to manage these responsive behaviours included: remove from public area when behaviour is disruptive or unacceptable; provide diversional activities, provide emotional support as needed; provide consistent caregivers; approach/speak in calm manner; discuss/explain/reinforce why behaviour is inappropriate and/or unacceptable; intervene as needed to protect the rights and safety of others; administer

medications as ordered and monitor for side effects and effectiveness; and allow opportunities for resident to pace safely.

Review of BAT assessment for Resident #046 indicated for "Sexual behaviour": "has strong sexual tendencies, will ask staff and co-residents to come to her/his room , has been observed demonstrating sexually inappropriate responsive behaviour towards co-residents and is looking for companionship". Interventions included: "closely monitoring" and "redirecting when gets too close to co-residents or acting suspiciously", staff to inform the resident that the co-residents are all married and sexually inappropriate responsive behaviour is not permitted.

The behavioural triggers were not identified for Resident #046 sexual inappropriate responsive behaviours until 3 weeks after the behaviours occured; additional strategies were not considered when the resident was reassessed when the strategies developed and implemented, were not effective, and the behaviours continued, and some of the strategies were not clear (i.e. “closely monitor” and “acting suspiciously”). [s. 53. (4)]

3. A Compliance Order was issued to the home on January 22, 2015 indicating the home must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies are developed to respond to responsive behaviours of wandering and elopement exhibited by Residents #049, #050 and any other resident exhibiting these behaviors. The licensee was also further ordered to ensure that actions taken to respond to the needs of the resident include assessments, reassessments, interventions and the resident's responses to the interventions are documented. The home's plan was to include:
- how and when the home will seek appropriate support if implemented strategies prove to be ineffective
- processes for monitoring that planned interventions for responding to responsive behaviors are implemented by staff and that the effect of the intervention is documented.
- a process for reassessment, monitoring and re-evaluation of best care strategies.
- provide education to all nursing staff specific to care planning and documentation relating to resident responsive behaviours of wandering and elopement.
- develop or implement a process to monitor that documentation includes identification of the responsive behaviours observed, triggers if any are identified, action taken by the staff and the response of the resident. The order was to be complied with by March 27, 2015.

Regarding Resident #049

Resident #049 was identified in the previous order as one of the residents at high risk for exhibiting wandering/elopement behaviors.

Review of care plan for Resident #049 identified the resident as being at risk for wandering related to history of elopement and the resident making statements that they are leaving. The interventions noted to address this responsive behavior are:
- apply wander guard to resident's ankle
- staff to check resident's whereabouts for safety q1h when in the building
- staff to re-direct resident if noted to be exit seeking
- receptions has been provided with the resident's picture and contact information

A Critical Incident Report (CIR) was submitted indicating the resident had eloped on an identified date and was found less than three hours later several kilometers away. The home indicated in the CIR, that video surveillance identified the resident had left the building through the front door.
The only additional strategy indicated was to place an arm band with the resident's name and home on the resident and the mobility aide.

Review of the progress notes indicate that prior to the incident,the resident had made another attempt to elope from the home.
- On an identified date receptionist called to report the resident had walked unaccompanied out of the building. At the time of the incident, the resident was wearing the wander guard alert but it did not alarm as he/she exited the building.

Interview with PSW #143 explained staff attempt to check for the whereabouts of the resident on a hourly basis but only completes documentation if the form is provided by the registered staff.

Review of the CIR indicated the video surveillance was reviewed and the resident had left the building via the front door . Staff noted the resident was not on the unit at an identified time.
On the date of the incident, there was no documentation found to support the last time the resident was seen on the unit even though the plan of care directs staff to monitor the resident q 1 hour.

There is no evidence to support the resident was reassessed or that additional strategies

have been considered when the strategies developed and implemented were not effective, and the behaviours continue.

Regarding Resident #050

Resident #050 was admitted to the home on an identified date and was identified in the previous compliance order issued to the home as nigh risk for exhibiting responsive behaviours of wandering/elopement.

A CIR was submitted by the home indicating that on an identified date Resident #050 was found by a staff member walking outside of the building and was escorted back to the home. The resident was unable to state what had happened.No injuries were noted. The resident had a history of elopement and wears a roam alert bracelet. The alarm sounded but staff did not locate anyone in the area and an environmental staff turned off the alarm.
The immediate actions taken to prevent recurrence included:
- increase monitoring, initiate DOS and provide additional education to the staff member who turned off the alarm without checking who had set off the alarm.

Review of the care plan for Resident #050 indicated the resident demonstrated wandering responsive behaviors related to ambulatory, cognitive impairment and making statements that they are leaving. The only two interventions identified are:
- apply wander guard to resident's wrist
- q 30 minute checks and documentation on DOS tool.

Review of the resident's clinical health records indicated the q 30 minutes checks were not being documented on the DOS tool. Interview with Staff #129 and #139 both indicated the DOS were not completed on an ongoing basis and are normally only completed for 7 days following an incident.

During an interview with RCC # 135 explained that following the incident a care conference was held with the resident's family but the strategy suggested was declined.

There is no evidence to support that any other strategies had been considered, when the strategies developed and implemented were ineffective and the resident continued to exhibit this responsive behavior.

Residents #049 and #050 demonstrates a history of elopement and are both at risk for actual harm. CIRs have been submitted to the Director in relation to elopement for both Resident #049 and #050. Although the home has received a Compliance Order related to responsive behaviour of wandering and elopement, there is no evidence that additional strategies have been considered when the strategies developed and implemented were not effective and the behaviours continued, hence non compliance continues. [s. 53. (4) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by other residents.

Under O.Reg.79/10, s.2(1) "sexual abuse" means, (b) an non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to log # 001568:

Review of the progress notes for Resident #046 related to sexually inappropriate responsive behaviours:
-the resident was admitted on an identified date with cognitive impairment and no prior responsive behaviours demonstrated.
-on an identified date, the resident was observed in the dining room demonstrating sexually (physical) responsive behaviour towards Resident #045.

-on an identified date, staff observed the resident in the hallway demonstrating sexually (physical) responsive behaviour towards Resident # 001.

-on an identified date, staff observed the resident sitting at the nursing station and attempted to demonstrate sexually (physical) responsive behaviour towards a co-resident (but staff intervened before the resident made contact). The resident was removed to the TV lounge area away from co-residents.

-on an identified date the PSW entered TV lounge after hearing a co-resident yelling. The PSW found the resident demonstrating sexually (physical) responsive behaviour towards Resident #045 . Staff intervened and removed Resident #045 from the TV lounge. The Director, Police and both families were notified of the sexually inappropriate behaviour demonstrated by Resident #046. A BAT and tip sheet was also completed at this time. There was no DOS completed.
-on an identified date, the resident was found in a co-resident's room - the co-resident was sleeping.
-on an identified date the PIECES assessment was completed due to referral for demonstrating sexually (physical) responsive behaviours.
There were no further incidents of inappropriate sexual behaviour documented.

Interview of BSO indicated they did not initiate assessments (but nursing is able to initiate DOS) until they were notified of sexually (physical) responsive behaviour on an identified date and that was when the tip sheet and BAT tool was initiated.
Interview of DOC indicated that she was unable to determine which co-resident's room Resident #046 was found. The DOC confirmed that neither an investigation or incident report had been completed by staff. The staff were also unable to identify the co-residents. The DOC indicated the Director & police should have been notified on identified dates but thinks the staff may not have called as there was no injury to the co-residents and they did not appear to be in distress.

Therefore, the licensee failed to protect Resident #001, #045 and unidentified co-residents, from sexually inappropriate responsive behaviours exhibited by Resident #046 as evidenced by:

-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as issued under WN #7 [LTCHA, 2007, s.20(1)].

-the licensee failed to ensure that the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the incidents that occurred on identified dates by Resident #046 towards Resident #045, Resident #001 and an unidentified co-resident, as issued under WN #12[O.Reg. 79/10, s.98].

-the licensee failed to ensure that every alleged, suspected, or witnessed incident of suspect sexual abuse of a resident by another resident, that resulted in harm or risk of harm, was immediately investigated, as the DOC confirmed that no investigation was completed into the incidents on identified dates, as issued under WN #8 [LTCHA, 2007, s.23(1)(a)(i)].

-the licensee failed to ensure that when a person had reasonable grounds to suspect sexual abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director, as the Director was not notified of the sexual abuse incident that occurred on identified dates until several weeks later and the incidents that occurred on identified dates was not reported, as issued under WN #9 [LTCHA, 2007, s.24(1)].

-the licensee failed to ensure the demonstrated sexually inappropriate responsive behaviours for Resident #046 had the behaviour triggers identified, that strategies were developed and implemented related to monitoring of the resident after the first incident; and for Residents ##001, #045 and the unidentified residents, on how to protect them from recurrence of inappropriate sexual responsive behaviour of other residents, where possible, as issued under CO #1 [O.Reg.79/10, s.53(4)(a)(b)].

Regarding Resident #047 (related to log # 002052 & # 001920):

Review of the progress notes for Resident #047 indicated the resident demonstrated sexually (physical) responsive behaviour towards Resident #048 on 2 separate occasions on the same day. Staff informed to "continue to monitor the resident". The physician was notified and medication was prescribed. Police and family, RCC, DOC and the Director were also notified.
-on an identified date, the resident was witnessed demonstrating sexually (physical) responsive behaviour towards an unidentified co-resident. The resident was redirected. BSO team was notified and BAT initiated due to ongoing sexually (physical) responsive behaviour. The resident was transferred to another unit.

-on an identified date, the resident was observed walking out of another co-resident's room and the co-resident was found sleeping. Staff "did not observe the resident entering the room". There was no indication which co-resident was involved.
-on an identified date, staff witnessed the resident demonstrating sexually (physical) responsive behaviour towards an unidentified co-resident. The resident "remained on DOS and every 15 minute checks".
-on an identified date the resident was transferred to another room, to be closer to the nursing station.
-on an identified date, a staff member observed the resident demonstrating sexually (physical) responsive behaviour towards Resident #001. The family, physician, police, and the Director were notified. The physician ordered an increase of the medication. The resident remained on every 15 minutes checks.
There were no further incidents of inappropriate sexual touching documented.

There was no documented evidence to indicate the SDM's of the unidentified residents were notified, an investigation was completed, or the police and Director were notified.

Interview of Staff #141 indicated Resident #047 wanders independently throughout the unit, is severely cognitively impaired, and no longer demonstrates any sexually inappropriate behaviours towards co-residents.

Interview of the DOC indicated she was unable to determine which co-residents were involved in the sexually inappropriate responsive behaviour that occurred on identified dates as neither incident reports nor investigations had been completed. She was also unable to determine if the SDM of the co- residents were notified. The DOC confirmed the police and the Director were not notified of those incidents.

Therefore, the licensee failed to protect Resident #001, #048 and 2 unidentified co-residents from sexually inappropriate responsive behaviours by Resident #047 as evidenced by:

-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with,as issued under WN #7 [LTCHA, 2007, s.20(1)].

-the licensee failed to ensure that the resident's SDM and any other person specified by the residents were immediately notified upon becoming aware of the alleged, suspected or witnessed incidents of sexual abuse that occurred on identified dates, as issued under

WN #11[LTCHA, 2007, s. 97(1)(a)].

-the licensee failed to ensure that the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the incidents that occurred on identified dates by Resident #047 towards Resident #048, Resident #001 and 2 unidentified co-resident, as issued under WN #12[O.Reg. 79/10, s.98].

-the licensee failed to ensure that every alleged, suspected, or witnessed incident of suspect sexual abuse of a resident by another resident, that resulted in harm or risk of harm, was immediately investigated, as the DOC confirmed that no investigation was completed into the incidents that occurred as issued under WN #8 [LTCHA, 2007, s.23(1)(a)(i)].

-the licensee failed to ensure that when a person had reasonable grounds to suspect sexual abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director, as the Director was not notified of the sexually inappropriate responsive behaviours that occurred on identified dates, as issued under WN #9 [LTCHA, 2007, s.24(1)].

-the licensee failed to ensure that the demonstrated responsive behaviours for Resident #047 had the behaviour triggers identified, that strategies developed and implemented were reassessed when it was determined that the strategies were not effective and other strategies considered, on how to protect co-residents from recurrence of sexually inappropriate responsive behaviour of other residents, where possible, as issued under CO #1 [O.Reg.79/10, s.53(4)(a)(b)]. [s. 19. (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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out the planned care for the resident.

Resident # 028 was admitted to the home on an identified date and had several medical diagnosis. The resident was totally dependent on staff for all activities of daily living.

The resident was observed using a tilt mobility aid on two consecutive days. The mobility aid was only observed in an upright position when the resident was being assisted with meals.

During an interview, Staff #121 explained the tilt mobility aid is being used to assist the resident with positioning and for comfort. The resident has been using the mobility aid for the last 6 months - the mobility aid is only placed in the upright position when the resident is being fed. The resident would lean forward if the chair was left upright due to postural instability.

During an interview, OT # 118 on July 20, 2015 explained the tilt mobility aid is not being used for the resident as a restraint or PASD, but for positioning due to the resident's postural instability. The resident does not make any attempts to get out of the tilt mobility aid.

Review of the clinical health records there is no mention that a tilt mobility aid is used for this resident. The written plan of care does not set out the planned care related to the tilt mobility aid for this resident. [s. 6. (1) (a)]

2. Resident # 004 has medical history that includes cognitive impairement.
Review of the resident's care plan , related to oral hygiene indicates the resident has full and lower dentures and requires assistance from 1 staff with daily cleaning of dentures or mouth care.

During an interview, both the resident and spouse indicated the staff do not assist with oral hygiene, that it is the resident's spouse that assists with cleaning of the resident's dentures. The resident's spouse visits on a daily basis just before lunch and likes to assist.

Interview with Staff # 131 and #132 indicated to the inspector staff do not clean the resident's dentures, as the resident's spouse does it on a daily basis. The resident's spouse comes in every day just before lunch.

The plan of care related to oral hygiene does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The licensee failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care.

During an observation of Resident #010, inspector #550 observed a small abrasion and 4 bruises on a specific area. There were also 2 small bruises on another area.

Interview with Staff # 134 indicated PSWs are to document on the skin observation tool on the first bath day of the week any new skin condition and then give the sheet to RPN for a follow-up. PSW skin observation tools were found , there is no documentation on the sheet for two weeks. Staff # 134 is unsure why, she indicated maybe PSWs possibly don't get that they have to document these.

Staff # 134 indicated the resident has fragile skin. The skin alterations to specific areas are often caused by the resident repositioning self. The staff have tried different options but the resident still has skin alterations.

Staff # 133 explained the PSW's are expected to complete the skin observation tool weekly on the first bath day and any time a change in skin condition is noted. The resident receives a bath on 2 specific days.

Treatment was not received because the staff failed to document there was a change in the resident's skin condition. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Resident #029 has a care plan related to falls prevention with the most recent dated approximately 7 months ago. Since that date, Resident #029 has sustained 7 falls, over a 6 month period.

Resident #035 has a care plan related to falls prevention with the most recent dated 11 months ago. Since that date, Resident #035 has fallen 3 times, over a 10 month period.

On July 22, 2015 discussion held with the home’s RAI Coordinator. She verified the falls prevention care plans for Resident #029 and #035 had not been updated to reflect the resident’s ongoing falls and revision of the interventions when they were not effective in reducing or mitigating the incidence of falls. [s. 6. (10) (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 the plan of care sets out the planned care for the resident., clear directions to staff and others who provide direct care., the provision of the care set out in the plan of care is documented.the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

The home was issued noncompliance during the RQI inspection in December 2014 for the same areas.

On July 13, 2015 at 10:30, during the initial tour the following was observed:
1)The following shower rooms had wood panelled walls with large areas of heavily scuffed surfaces exposing raw wood and rendering unable to clean:
- 3 units on the 2nd floor
-4 units on the 3rd floor

- 3 units on the 4th floor

On July 13, 2015 at 10:30, during the initial tour of the home the following tub/shower rooms were observed to have large areas of heavily soiled floors:
- 3 units on 2nd floor.
- 2 units on 3rd floor
- 2 units on 4th floor
2) The following tub rooms had the blue rubber edging around the tubs falling off approximately 2 feet long exposing sharp edges:
-1 unit on 2nd floor
-2 units on 4th floor [s. 15. (2) (c)]

2. The maintenance worker indicated no knowledge of identified tubs with blue trim coming off. Indicated they have come off in the past but could not recall which tubs were repaired and had no record of maintenance completed. He was unable to provide communication books completed prior to May 2015. He further indicated he had no knowledge of blue trims on all tubs were being replaced and indicated when he replaced one in the past had to be completed after hours as the glue had a strong smell and took a couple of hours to dry.

Interview of Environmental Services Manager(ESM) indicated he was aware of the blue trim coming off the tubs, worn wood paneled walls in the tub/shower rooms, and the heavily stained tub/shower room floors. The ESM indicated approval was given in February or March 2015 for renovations to be completed (on the wood panels and floors) "as they need to be replaced" and cannot be cleaned. The ESM indicated that quotes had not yet been received from the company that had orginally laid the flooring and the ESM had not contacted anyone for quotes regarding the wood panelling walls. The ESM indicated "an order had been put put in to have the blue trim replaced on all the tubs" as the home has had ongoing issues with the trims falling off and having to be reglued. [s. 15. (2) (c)]

3. The ESM provided an email indicating that on June 10, 2015 a company was contacted regarding the blue trim falling off the tubs. The home determined that 5 tubs required new trim kits installed and a quote was provided on June 11, 2015. The work has not yet been completed to date. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home, furnishings and equipment are kept clean and sanitary and maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system that uses sound to alert staff, is it properly calibrated so that the level of sound is audible to staff.

For the purpose of this report the resident-staff communication and response system is often referred to as the call bell system.

On July 15 and 16, 2015 it was observed by Inspectors that when the resident-staff communication and response system was activated in different rooms on different units, it was not audible to staff.

Inspector #552 observed the call bell in a room on the 3rd floor was not audible to staff when activated. Inspector #550 observed that when activated, the call bell in a room on the 2nd floor would light up but it was not audible to staff and that many of the call bells on different units were barely audible or not audible to staff as follows:

Pineridge Place: hallway leading to resident's rooms
Moonlight Bay: hallway leading to resident's rooms
Golden Pond: hallway leading to resident's rooms
Willow Way: hallway leading to resident's rooms
Primerose Path: hallway leading to resident's rooms
Honey Harbour: hallway leading to resident's rooms

Staff #105 and 113 were interviewed and explained the annunciator for the call bell system is located at the nursing station on each unit and the sound is not audible throughout the unit. It is audible from the hallways that are close to the nursing station only.

Staff #114, 115, 116 and 117 from several units were interviewed and they all indicated that the call bells could not be heard from certain hallways on their unit or the sound is very faint.

During an interview, the ESM indicated after the home's last Resident Quality Inspection the environmental department staff had verified and adjusted the calibration of all the nursing call system in each nursing station as they observed that many of them had the volume turned low. They had also installed an extra annunciator in the nursing sub-station but only on Willow Way unit. He further indicated that it was possible that staff had lowered the volume on the nursing call bell system again since many of them had complained of the sound being very loud inside the nursing station when they were in there working. He indicated it was approved in the capital budget for this year to replace the nursing call bell system but that this would not occur before the end of the year. The ESM indicated the home does not have any monitoring system in place to ensure functionality of the nursing call bell system; they rely on feedback from staff. [s. 17. (1) (g)]

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-staff communication and response system that uses sound to alert staff, is it properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition

Regarding log # 002478-15

A Critical Incident Report (CIR) was submitted by the home on an identified date. The CIR indicated that on on an identified date, Resident #049 was noted to be absent from the unit. Code yellow was called, internal and external search was completed but the resident was not located. The resident's POA and police were notified. The code was canceled when the resident was found and returned to the home with no injuries.

The home failed to ensure the incident was reported to the Director within one business day [s. 107. (3) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of the home's policy "Abuse & Neglect-Prevention, Reporting & Investigating" (ADM-01-03-05) (revised May 2015) indicated:

-Under sexual abuse (page 3): any touching of a resident that is of a sexual nature and any behaviour or remarks of a sexual nature towards the resident, including remarks that are sexually provocative, demeaning, humiliating exploitative or derogatory.

-Under Reporting/Investigating (page 6) :all staff, volunteers, contractors and affiliated personnel must immediately report any alleged, suspected or witnessed incidents of abuse or neglect to the appropriate supervisor on duty. Together, with the person who witnessed the alleged/suspected/witnessed abuse or neglect, the home must immediately report to the MOHLTC. Staff must follow two types of reporting procedures

(internal and external) for the reporting of alleged, suspected or witnessed incidents of abuse or neglect.

-Under internal reporting (page 9): if the resident who committed "verbal or emotional abuse" does not understand the consequences of his/her actions, staff will complete an incident report in the home's software and document the follow-up interventions used in order to minimize re-occurrence of this type of event.

-on page 8, provides a table which includes "Types of Incident in the LTC Home", "Actions to be taken by the LTC home" and "reporting time frame" but sexual abuse is not included in this table.
This policy does not meet the legislative requirement as there is no direction as to how staff are to respond to resident to resident "sexual abuse" when the resident who committed the sexual abuse does not understand the consequences of his/her actions.

Regarding Resident #047 (Related to Log # 001920 & 002052):
Review of the progress notes for Resident #047 indicated on three identified dates (as identified under WN #2), there were witnessed and/or suspected incidents of resident to resident sexual abuse that occurred.

Regarding Resident #046 (Related to Log #001568):
Review of the progress notes for Resident #046 indicated on three identified dates (as identified under WN #2), there were witnessed incidents of resident to resident sexual abuse that occurred.

Interview of the DOC indicated that all staff had received mandatory training and annual re-training on the home's policy on prevention of abuse and neglect. The DOC indicated no investigation was completed into the identified incidents as there was no internal incident reports completed for the identified dates.

There was no indication the home's policy was followed as the staff did not report to supervisor/manager, no internal incident reports were completed, no investigation into the incidents, and the MOHLTC was not notified. [s. 20. (1)]

WN #8: 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 is reported is immediately investigated: (i) abuse of a resident by anyone.

Regarding Resident #046 (Related to log # 0001568):

Interview of DOC indicated the incidents that occurred on identified dates with Resident #046 (as identified under WN # 1) had no investigation completed. [s. 23. (1) (a)]

2. Regarding Resident #047 (Related to log # 002052 & # 001920):

Interview of the DOC indicated she was unable to determine the identity of co-residents who were involved in the sexually inappropriate responsive behaviour demonstrated by Resident #047 that occurred on an identified date, as there were no incident reports completed and no documented evidence of an investigation. [s. 23. (1) (a)]

WN #9: 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 sexual abuse of a resident by another resident that had occurred, and resulted in a risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

Regarding Resident #046 (Related to Log # 001568):

Interview of the DOC indicated that the Director & police should have been notified of the incidents that occurred on an identified date but "thinks the staff may not have called as there was no injury to the co- resident's and the resident's did not appear in any distress".

The incident that occurred on an identified date was not reported until three weeks later. The other incidents that occurred on 2 separate dates was not reported to the Director. [s. 24. (1)]

2. Regarding Resident #047 (Related to log # 002052 & # 001920):

Interview of the DOC indicated the Director was not notified of the incidents that occurred on identified dates. [s. 24. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident is incapable, by the SDM.

Resident #031 was observed with a trunk restraint in place while up in a mobility aid.

Review of the home's policy "Restraint Minimization-physical, emergency physical and emergency chemical" (INTERD-03-04-01)(reviewed December 2014) indicated under procedure for the use of physical restraints:
-obtain and record informed consent from resident or SDM.
-(on page 4 of 11) the need for the restraining device will be reviewed and assessed by the resident/substitute decision-maker and the interdisciplinary care team during the annual care conference as part of the "safety risk assessment".

Interview of the RAI Coordinator indicated the use of the restraint is to be reviewed annually with the SDM at the care conference.

Interview of Staff #102 indicated that any resident using a restraint would have to have the SDM consent. Staff #102 indicated the use of the restraint would also be reviewed annually with the family at the care conference and would be documented.

Review of the annual "interdisciplinary care conference" indicated under restraints "n/a".

There was also no documented evidence Resident #031 had the use of the restraint reviewed annually with the SDM at the care conference. [s. 31. (2) 5.]

WN #11: 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 has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Regarding Resident #047 (Related to log # 002052 & # 001920):

Interview of the DOC indicated she was unable to determine the identity of the co-residents involved in the sexually inappropriate responsive behaviour demonstrated by Resident #047 that occurred on identified dates as there was no documented incident reports completed (or to determine if the SDM were notified). [s. 97. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Regarding Resident #046 (Related to log # 001568):

Review of the progress notes for Resident #046 indicated:
-on an identified date the resident was observed demonstrating sexually inappropriate responsive behaviour towards Resident #045.
-on an identified date a PSW observed the resident in the hallway demonstrating sexually inappropriate responsive behaviour towards Resident #001.
-on an identified date a PSW reported , the resident was observed demonstrating sexually inappropriate responsive behaviour towards an unidentified co-resident.

The incident on the identified dates were not reported to the police.

Interview of the DOC indicated the Director & police should have been notified of the identified incidents but "thinks the staff may not have called as there was no injury to the co-residents and they did not appear to be in any distress". [s. 98.]

2. Regarding Resident #047 (Related to log # 002052 & # 001920):

Interview of the DOC confirmed that police were not notified of the incidents that occurred. [s. 98.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Regarding Resident #031 related to the use of a table top restraint.

The licensee failed to ensure that the documented use of a physical device to restrain a resident under section 31 of the Act, included all assessments and reassessments.

Resident #031 was observed with a trunk restraint in place while up in the wheelchair.

Review of the home's policy "Restraint Minimization-physical, emergency physical and emergency chemical" (INTERD-03-04-01)(reviewed December 2014) indicated under procedure for the use of physical restraints:
-include interdisciplinary team members in resident assessment.
-each home is required to ensure an analysis of residents being restrained by use of a physical device is undertaken on a monthly basis. The policy did not indicate how the reassessment would be completed.

Interview of RAI Coordinator indicated that any resident using a restraint should be reassessed on a quarterly basis in MDS and a RAP summary completed to indicate why the restraint is still required. The RAI Coordinator indicated the nurses on each unit is responsible to complete their own assigned resident's MDS. The RAI Coordinator confirmed the use of the restraint was not indicated as "in use" in the most recent MDS assessment and no RAP summary note was completed (for Resident #031) despite the use of a trunk restraint. The RAI Coordinator also indicated the care plan for Resident #031 had not been reviewed or revised regarding the use of the trunk restraint for more than six months.

Interview of Staff #102 indicated that any resident using a restraint would be reviewed "quarterly" on MDS. Staff #102 indicated nurses completing the MDS assessment "would only select which restraint was being used" but not necessarily complete a RAP summary note (to indicate why the restraint was still required).

Interview of the DOC indicated that all residents with physical restraints are to be reviewed quarterly using the RAI-MDS. The DOC was not aware the home's policy indicated that use of the restraints were to be reviewed "monthly".

Review of the health care record for Resident #031 had no documented evidence Resident #031 was reassessed quarterly (or monthly as per the home's policy), regarding the use of the trunk restraint and the resident was palliative. [s. 110. (7) 6.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Issued on this 29th day of October, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA FRANCIS-ALLEN (552), JOANNE HENRIE (550), KATHLEEN SMID (161), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2015_291552_0019
Log No. / Registre no:	O-002388-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 28, 2015
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	HILLSDALE ESTATES 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Peragine

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_195166_0033, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that behavioural triggers are identified and strategies are developed to respond to responsive behaviors of non-consensual sexual touching exhibited by Resident #047 and to wandering/elopement exhibited by Resident #049 and #050 any other resident exhibiting these behaviours.

The licensee will further ensure that actions taken to respond to the needs of Resident #047, # 049 & # 050 and any other resident exhibiting responsive behaviours of non-consensual sexual touching and/or wandering/elopement includes: assessments, reassessments, interventions and the resident's response to the interventions are documented.
These actions will include:
- documentation of all interventions developed to respond to the needs of the resident
- reassessment, monitoring and re-evaluation of strategies
- providing clear direction to staff as to next steps when strategies developed are ineffective
- seek appropriate support if implemented strategies provided prove to be ineffective
- inform staff of increased risk of responsive behaviors at shift report
- processes for monitoring that planned interventions for responding to responsive behaviours are implemented by staff and the effect of the intervention is documented
- ongoing education to staff regarding related to wandering/elopement and sexually inappropriate responsive behaviours.

Link with Inspection #: 2014_195166_0033

Grounds / Motifs :

1. Regarding Resident #46 (Related to Log # 001568):

A Critical Incident Report (CIR) was received by the Director on an identified date for a resident to resident sexual abuse incident. The CIR indicated on an identified date, a PSW observed Resident #046 demonstrating sexually inappropriate responsive behaviour towards Resident #045 . Resident #045 was placed near nursing station for "closer monitoring". On an identified date, a PSW heard Resident #045 yelling from room and found Resident #046 in

Resident #045 room, demonstrating sexually inappropriate responsive behaviour. Resident #046 was immediately removed from the room of Resident #045. The CIR indicated the BSO team was notified & increased monitoring with DOS and BAT tools. The CIR indicated "the physician was notified several days later.

Review of the progress notes for Resident #046 indicated:
- the resident was admitted to the home on an identified date and was cognitively impaired
-over an 11 day period, the resident demonstrated(physical) sexually inappropriate responsive behaviours 9 times towards Residents' # 001, #045 and other unidentified co-residents. Staff interventions included : removing the resident from the area, referring the resident to the BSO team, completion of DOS (on one occasion) and completion of the PIECES assessment. The police was notified on 1 occasion.The resident also demonstrated (both verbal and physical) sexually inappropriate behaviors towards staff members.
- over this time frame, the physician was notified three times of these behaviours and medication was ordered on one occasion and dosage reviewed on another occasion.

Review of the care plan for Resident #046 indicated the resident was cognitively impaired and exhibited responsive behaviours of: wandering and inappropriate sexual behaviour. Interventions to manage these responsive behaviours included: remove from public area when behaviour is disruptive or unacceptable; provide diversional activities, provide emotional support as needed; provide consistent caregivers; approach/speak in clam manner; discuss/explain/reinforce why behaviour is inappropriate and/or unacceptable; intervene as needed to protect the rights and safety of others; administer medications as ordered and monitor for side effects and effectiveness; and allow opportunities for resident to pace safely.

Review of BAT assessment for Resident #046 indicated for "Sexual behaviour": "has strong sexual tendencies, will demonstrated sexually inappropriate responsive behaviours (verbal and physical) towards co-residents, and is looking for companionship". Interventions included: "closely monitoring" and "redirecting when gets too close to co-residents or acting suspiciously", staff to inform the resident that the co-residents are all married and inappropriate touching is not permitted.

The behavioural triggers were not identified for Resident #046 sexually inappropriate responsive behaviours until 3 weeks after the behaviours occurs and additional strategies were not considered when the resident was reassessed when the strategies developed and implemented, were not effective, and the behaviours continued, and some of the strategies were not clear (i.e. "closely monitor" and "acting suspiciously"). (111)

2. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours (b) strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible; (c)that actions taken to meet the needs of the resident with responsive behaviours include:
* assessment
* reassessments
* interventions, and
* documentation of the resident's responses to the interventions

Regarding Resident #047 (related to log # 002052 & # 001920):

Review of the progress notes for Resident #047 indicated the resident was witnessed demonstrating sexually inappropriate responsive behaviours towards Resident #048 on two separate times on the same date.. The resident was witnessed demonstrating sexually (physical) inappropriate responsive behaviour towards three unidentified co-residents on three different dates. The resident was witnessed several days later demonstrating sexually inappropriate responsive behaviour towards Resident #001..

Review of health record for Resident #047 indicated:
-the resident was on every 15 minute checks for 2 weeks
-the resident was on hourly checks 10 days
-the resident was on DOS (hourly dementia observation system) for approximately 3 weeks (with several blank entries).
-the BAT (behavioural assessment tool) indicated the resident demonstrated sexually inappropriate responsive behaviours... No triggers were identified. The interventions included: relocation to another unit, every 15 minute checks, medication, DOS tool, specimen collection, and every 30 minute checks to commence after the medication is increased to higher recommended dose.

-a consultation report from Ontario Shores and a tip sheet provided strategies to

manage the sexually inappropriate responsive behaviour.

The behavioural triggers were not identified for Resident #047 sexually inappropriate responsive behaviour towards co- residents. Strategies were not developed and implemented for Resident #047 until after the third incident of sexually inappropriate responsive behaviours . Strategies identified by Ontario Shores were not implemented until after the behaviours discontinued. (111)

3. A Compliance Order was issued to the home on January 22, 2015 indicating the home must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies are developed to respond to responsive behaviours of wandering and elopement exhibited by Residents #049, #050 and any other resident exhibiting these behaviors. The licensee was also further ordered to ensure that actions taken to respond to the needs of the resident include assessments, reassessments, interventions and the resident's responses to the interventions are documented. The home's plan was to include:
- how and when the home will seek appropriate support if implemented strategies prove to be ineffective
- processes for monitoring that planned interventions for responding to responsive behaviors are implemented by staff and that the effect of the intervention is documented.
- a process for reassessment, monitoring and re-evaluation of best care strategies.
- provide education to all nursing staff specific to care planning and documentation relating to resident responsive behaviours of wandering and elopement.
- develop or implement a process to monitor that documentation includes identification of the responsive behaviours observed, triggers if any are identified, action taken by the staff and the response of the resident. The order was to be complied with by March 27, 2015.

Regarding Resident #049

Resident #049 was identified in the previous order as one of the residents at high risk for exhibiting wandering/elopement behaviors.

Review of care plan for Resident #049 identified the resident as being at risk for wandering related to history of elopement and the resident making statements

that they are leaving. The interventions noted to address this responsive behavior are:
- apply wander guard to resident's ankle
- staff to check resident's whereabouts for safety q1h when in the building
- staff to re-direct resident if noted to be exit seeking
- receptions has been provided with the resident's picture and contact information

A Critical Incident Report(CIR) was submitted on an identified date indicating the resident had eloped on an identified date and was found less than 3 hours later, several kilometers away. The home indicated in the CIR, that video surveillance identified the resident left the building through the front door at an identified time. The only additional strategy indicated was to place an arm band with the resident's name and home on the resident and the mobility aide.

Review of the progress notes indicate that prior to the incident , the resident made an attempt to elope from the home.
- On an identified date, receptionist called to report the resident had walked out of the building unaccompanied. At the time of the incident, the resident was wearing the wander guard alert but it did not alarm as the resident exited the building.

Interview with PSW # 143 on July 22, 2015 explained staff attempt to check for the whereabouts of the resident on a hourly basis but only completes documentation if the form is provided by the registered staff.

Review of the CIR indicates the review of the video surveillance identified the resident left the building through the front door at an identified time Staff noted the resident was not on the unit approximately 2 hours later.
On the date of the incident, there was no documentation found to support the last time the resident was seen on the unit even though the plan of care directs staff to monitor the resident q 1 hour.

There is no evidence to support the resident was reassessed or that additional strategies have been considered when the strategies developed and implemented were not effective and the behaviour continued.

Regarding Resident #050

Resident #050 was admitted to the home on an identified date and was identified in the previous compliance order issued as high risk for exhibiting responsive behaviours, of wandering/elopement.

A CIR was submitted by the home indicating that on an identified date Resident #050 was found by a staff member walking outside of the building and was escorted back to the home. The resident was unable to state what had happened.
The resident had last been seen in the home at a specified time and was returned to her home area 15 minutes later. No injuries were noted. The resident has a history of elopement and wears a roam alert bracelet. The alarm sounded but staff did not locate anyone in the area and an environmental staff turned off the alarm.
The immediate actions taken to prevent recurrence included:
- increase monitoring, initiate DOS and provide additional education to the staff member who turned off the alarm without checking who had set off the alarm.

Review of the care plan for Resident #050 indicated the resident demonstrated wandering responsive behaviors related to ambulatory, cognitive impairment and making statements that they are leaving. The only two interventions identified are:
- apply wander guard to resident's wrist
- q 30 minute checks and documentation on DOS tool.

Review of the resident's clinical health records indicate the q 30 minutes checks are not being documented on the DOS tool. Interview with Staff #129 and #139 both indicated the DOS are not completed on an ongoing basis and are normally only completed for 7 days following an incident.

During an interview with RCC #135 explained that following the incident a care conference was held with the resident's family but the strategy suggested was declined.

There is no evidence to support that any further strategies had been considered, when the strategies developed and implemented were ineffective and the resident continues to exhibit this responsive behavior.

Residents #049 and #050 demonstrates a history of elopement and are both at risk for actual harm due to this behavior. CIRs have been submitted to the

Director in relation to elopement for both these residents. Although the home has received a Compliance Order related to responsive behaviours, non compliance related to identifying behavioral triggers, development of strategies to respond to responsive behaviors of wandering and elopement and the documentation of considered approaches for those strategies identified remains ineffective and non compliance continues.
(552)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2015

Order # / Ordre no : 002

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

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 will prepare, submit and implement a plan for achieving compliance to ensure that residents are protected from sexual abuse.

The licensee shall ensure the plan includes:
1) The development and implementation of a monitoring process to ensure that:
a) the resident's SDM is immediately notified of every alleged, suspected or witnessed incident.
b) every alleged,suspected or witnessed incident of sexual abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken to ensure the safety of those residents involved (and any other resident who may be vulnerable).
c) the Director is immediately notified if there are reasonable grounds to suspect the sexual abuse of a resident
d) the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of sexual abuse that the licensee suspects may constitute a criminal offence.
2) All staff and management to review and revise the home's policy related to Abuse to ensure the policy meets legislative requirements (specifically with resident to resident sexual abuse). The policy should also include actions to be taken by any person when a suspicion, allegation or witnessed incident of sexual abuse has been reported, ensuring awareness of roles and responsibility, and ensuring staff clearly understand who will be responsible for completing the investigation and that the investigation is to be completed immediately and appropriate actions are taken as a result of the investigation
3) Develop and implement a system to monitor and evaluate staff adherence to the Abuse policy.
4) Develop and implement specific measure to be in place when non-adherence to the home's policy or legislation is identified.
5) the plan should also identify who is responsible for ensuring the completion of each and every item listed above

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing Maria Francis-Allen at maria.francis-allen@ontario.ca on or before August 31, 2015. The plan shall identify who will be responsible for each of the corrective actions listed and expected time for completion

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by other residents.

Under O.Reg.79/10, s.2(1) "sexual abuse" means, (b) an non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The licensee has failed to ensure that residents are protected from abuse by other residents.

Under O.Reg.79/10, s.2(1) "sexual abuse" means, (b) an non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to log # 001568:

Review of the progress notes for Resident #046 indicated non-consensual touching occurred:
-the resident was admitted on an identified date with cognitive impairment and no prior responsive behaviours demonstrated.
-on an identified date, the resident was observed demonstrating sexually inappropriate behaviour towards Resident # 045..
-on an identified date staff observed the resident in the hallway demonstrating sexually (physical) responsive behaviour towards Resident #001.
-on an identified date, staff observed the resident sitting at the nursing station amd attempt to demonstrated sexually inappropriate responsive behaviour towards a co-resident (but staff intervened before the resident made contact). The resident was removed to the TV lounge area away from the co-residents.
-on an identified date, the PSW entered TV lounge after hearing a co-resident yelling. The PSW found Resident #046 demonstrating sexual inappropriate responsive behaviors towards Resident #045 . Staff intervened and removed Resident #045 from the TV lounge. The Police and both families were notified of the sexually inappropriate responsive behaviour exhibited by the resident. The Director was notified of the incident that occurred on two identified dates. A BAT and tip sheet was also completed at this time. There was no DOS completed.
-on an identified date, the resident was found in a co-resident's room - the co-resident was sleeping.
-on an identified date the PIECES assessment was completed due to referral for sexually inappropriate responsive behaviours.

There were no further incidents of inappropriate sexual behaviour documented.

Interview of BSO indicated they did not initiate assessments (but nursing is able to initiate DOS) until they were notified of sexually inappropriate responsive behaviours on an identified date and that was when the tip sheet & BAT tool was initiated.
The DOC confirmed neither an investigation nor incident reports had been completed for the incidents on the 3 identified dates and the staff were unable to recall who the (unidentified) co-residents were. The DOC indicated the Director & police should have been notified on 2 identified dates, but thinks the staff may not have called as there was no injury to the co-residents and the residents did not appear in any distress.

Therefore, the licensee failed to protect Resident #001, #045 and 2 unidentified co-residents from sexualy inappropriate responsive behaviours demonstrated by Resident #047 as evidenced by:

-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as issued under WN #7 [LTCHA, 2007, s.20(1)].

-the licensee failed to ensure the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the incidents that occurred on identified dates by Resident #046 towards Resident #045, #001 and an unidentified co-resident, as issued under WN #12 [O.Reg. 79/10, s.98].

-the licensee failed to ensure that every alleged, suspected, or witnessed incident of suspect sexual abuse of a resident by another resident, that resulted in harm or risk of harm, was immediately investigated, as the DOC confirmed that no investigation was completed into the incidents on 3 identified dates, as issued under WN #8 [LTCHA, 2007, s.23(1)(a)(i)].

-the licensee failed to ensure that when a person had reasonable grounds to suspect sexual abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director, as the Director was not notified of the sexual abuse incident that occurred on an identified date until 5 months later and the incidents that occurred on 2 identified dates were not reported, as issued under WN #9 [LTCHA, 2007, s.24(1)].

-the licensee failed to ensure that the demonstrated responsive behaviours exhibited by Resident #046 had the behaviour triggers identified, that strategies were developed and implemented related to monitoring of the resident after the first incident; and for Residents #001, #045 and the unidentified resident, on how to protect them from recurrence of sexually inappropriate responsive behaviours of other residents, where possible, as issued under CO #1 [O.Reg.79/10, s.53(4)(a)(b)].

Regarding Resident #047 (related to log # 002052 & # 001920):

Review of the progress notes for Resident #047 indicated the sexually inappropriate responsive behaviours occurred:
-on an identified date,, when the resident was witnessed by a staff to demonstrated sexually inappropriate responsive behaviour towards Resident #048 twice on the same date.. Staff were directed to "continue to monitor the resident". The physician was notified and prescribed medication to be administered daily. Police and family, RCC, DOC and the Director were also notified.
-on an identified date, the resident was witnessed demonstrating sexually inappropriate responsive behaviour towards an unidentified co-resident. The resident was redirected. BSO team was notified and BAT initiated . The resident was transferred to another unit.to remove the resident away from Resident #048.
-on an identified date, the resident was observed walking out of another unidentified co-resident's room.. Staff did not observe the resident entering the room.
-on an identified date, staff witnessed the resident demonstrating sexually inappropriate responsive behaviour towards an unidentified co- residents'. The resident “remained on DOS and every 15 minute checks”.
-on an identified date the resident was transferred to another room.
-on an identified date a resident was heard stating "stop that!" .l. The staff member then observed Resident # 047 demonstrating sexually inappropriate responsive behaviour towards Resident #001. The family, physician, police, and the Director were notified. The physician ordered increase medication dosage. The resident remained on every 15 minutes checks.
There were no further incidents of inappropriate sexual touching documented.

There was no documented evidence to indicate the SDM's of the unidentified

residents were notified, that an investigation was completed, or the police and Director were notified.

Interview of Staff #141 indicated since moving to a new unit, Resident #047 no longer demonstrates any sexually inappropriate responsive behaviours towards staff or residents..

Interview of the DOC indicated she was unable to identify 2 of the co- residents Resident # 047 had demonstrated sexually inappropriate responsive behaviour to because incident reports and investigations had not been completed.. She was also unable to determine if the SDM of the co- residents were notified. The DOC indicated the police and the Director were also not notified of those incidents.

Therefore, the licensee failed to protect Resident #001, #048 and 2 unidentified co-residents from sexual abuse by Resident #047 as evidenced by:

-the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with,as issued under WN #7 [LTCHA, 2007, s.20(1)].

-the licensee failed to ensure the resident's SDM and any other person specified by the residents were immediately notified upon becoming aware of the alleged, suspected or witnessed incidents of sexual abuse that occurred on 3 identified dates, as issued under WN #11 [LTCHA, 2007, s. 97(1)(a)].

-the licensee failed to ensure that the appropriate police force was immediately notified of a suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence as the police were not notified of the incidents that occurred onthe 3 identified dates by Resident #047 towards Resident #001, #048 and 2 unidentified co-residents, as issued under WN #12 [O.Reg. 79/10, s.98].

-the licensee failed to ensure that every alleged, suspected, or witnessed incident of suspect sexual abuse of a resident by another resident, that resulted in harm or risk of harm, was immediately investigated, as the DOC confirmed that no investigation was completed for the incidents on 3 identified dates, as issued under WN #8 [LTCHA, 2007, s.23(1)(a)(i)].

-the licensee failed to ensure that when a person had reasonable grounds to suspect sexual abuse of a resident by another resident that resulted in risk of harm, was immediately reported to the Director, as the Director was not notified of the sexual abuse incident that occurred on 3 identified dates, as issued under WN #9 [LTCHA, 2007, s.24(1)].

-the licensee failed to ensure that the demonstrated sexually inappropriate responsive behaviours of Resident #047 had the behaviour triggers identified, that strategies developed and implemented were reassessed when it was determined that the strategies were not effective and other strategies considered, on how to protect co- residents from recurrence of sexually abusive behaviour of other residents, where possible, as issued under CO #1 [O.Reg.79/10, s.53(4)(a)(b)]. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria Francis-Allen

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