Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 10, 2018	2018_324535_0013	028528-18	Critical Incident System

Licensee/Titulaire de permis

The Kensington Health Centre
25 Brunswick Avenue TORONTO ON M5S 2L9

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

The Kensington Gardens
25 Brunswick Avenue TORONTO ON M5S 2L9

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 26, 29, 30, November 1, 2, and off-site interview on November 8, 2018.

The following intake was completed in this critical incident inspection: Log #028528-18 related to resident to resident altercation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nurse Manager (NM), Social Worker (SW), Resident Assessment Instrument (RAI) Coordinator, registered staff (RN/RPN) and personal care associates (PCA).

During the course of the inspection, the inspector conducted observations, record reviews and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001 was protected from abuse by anyone.

Ontario Regulation 79/10, s. 2 (1) (c) indicated physical abuse means the use of physical force by a resident that causes physical injury to another resident.

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001's responsive behavior which caused resident #002 to sustain an injury for which they were transferred to the hospital and had a procedure.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date to have responsive behaviors.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date to have identified responsive behaviors as well.

Record review of the progress notes indicated, and interview with registered staff RPN # 104 verified, that on an identified date and time, a personal care associate (PCA) was accompanying resident #001 and #002 to the dining room. However, resident #002 started displaying a responsive behavior; and that immediately prompted resident #001 to reach over to push resident #002; however the PCA intervened and resident #002 was not harmed during the altercation.

Record review of the critical incident indicated, and interviews with registered staff RPN #104 and private companion #105, verified that on an identified date and time, resident #001 was walking in the corridor, accompanied by private companion #105. Resident #002 was walking along the same corridor; then resident #002 suddenly had an identified responsive behavior and resident #001 immediately lunged towards resident #002 and pushed the resident causing them to experience a fall to the floor with an injury. During the interview, private companion #105 stated that they attempted to separate both residents but was pushed aside by resident #001.

Record review indicated resident #001 remained calm for the rest of the shift. However, resident #002 was transferred to the acute care hospital where they were diagnosed with an injury which required a procedure.

During an interview, DRC #100 verified that after the incident occurred, the home initiated a specific strategy to support resident #001 during the evening shift in addition to the intervention already implemented during the dayshift. The progress notes indicated that on an identified date, the home's internal assessment team accompanied resident

#001 to the acute care hospital for an assessment; and specific a treatment was recommended and implemented.

DRC #100 verified during an interview that they were not aware of the number of incidents involving resident #001 until they read the progress notes. DRC #100 also stated the gap in care was that the level of risk was not identified by the team. Furthermore, DRC #100 stated they viewed the incident differently although the incident resulted in an injury. The incident was not reported to the Director as abuse. According to the DRC, there was no intent to harm since they both did not understand the circumstance of their actions; hence the situation was not thought of as abuse. During the interview, the inspector explained the licensee's duty to protect residents from abuse by anyone under s. 19 (1) of the LTCHA, 2007; and the DRC acknowledged they understood the reasoning. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The Ministry of Health (MOH) received a critical incident on an identified date, related to

resident #001's responsive behavior which caused resident #002 to sustain an injury.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date, and indicated to have identified responsive behaviors.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date; and indicated to have identified responsive behaviors.

On an identified date, the inspector observed the location of both residents' rooms along the back corridor on the unit. Record review indicated, and staff interviews verified that both residents resided in the same corridor; and their paths could cross on the unit.

A review of resident #001 identified assessment tool on a specific date indicated behaviors of concern. A review of the resident's written care plan indicated that on an identified date, an entry was made indicating the resident's responsive behavior triggers.

A review of the critical incident indicated, and interviews with registered staff RPN #104 and private companion #105 verified that resident #001 exited their room and was walking in the corridor with the private companion #105. Resident #002 was walking along the same corridor and suddenly resident #002 displayed a responsive behavior. Resident #001 immediately moved towards resident #002 and pushed the resident to the floor which caused an identified injury.

During interviews, the home's internal assessment team Co-Leads RPN #102 and SW #103 verified they were aware of resident #001 responsive behaviors; resident #002 responsive behaviors; and that both residents walked in the same corridor; however, they never thought of relocating one resident to another area of the unit to reduce the risk of their paths crossing which could potentially cause harmful interactions.

During an interview, the DRC verified that in the past, they had discussions with resident #001's POA related to transferring the resident to another area in the home and transferring the resident to another secured unit in the home. However, there were no beds available and both units also had vulnerable residents and were therefore not suitable. There was no indication the team discussed relocating resident #002 to another secured area of the home to eliminate the risk of altercation and potential harmful interactions given both residents identified responsive behaviors and resident #001

identified trigger.

Therefore, the home failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions to separate both residents. [s. 54. (b)]

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

Findings/Faits saillants :

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

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001's responsive behavior which caused resident #002 to sustain an injury.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date to have responsive behaviors.

On an identified date, the external resource support team assessed the resident and identified a possible trigger. They had specific recommended related to monitoring of the resident's interactions with co-residents.

A review of the resident's written care plan indicated that on an identified date, an entry was made indicating that the resident may hit staff and surrounding people related to a triggered behavior; however the additional information was not added to the resident's plan of care to ensure re- direction of co-residents away from resident #001 if they displayed triggered behaviors. This specific intervention was updated to the written care plan at a later date after the second altercation between both residents which resulted in injury.

During an interview, private companion #105 verified that prior to the incident which resulted in the injury, they were not aware of the intervention to redirect co-resident's away from specific residents in the home. During an interview, the DRC verified that residents' written plan of care should have been updated with the required information. Therefore, the home failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #001. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001's responsive behaviors which caused resident #002 to sustain an injury.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date to have responsive behaviors. On an identified date, the external resource team assessed the resident. identified a possible trigger; and recommended to monitor the resident's interactions with co-residents.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date to have responsive behaviors.

A review of the critical incident indicated, and interviews with registered staff RPN #104

and private companion #105 verified that resident #001 exited their room and was walking in the corridor with the private companion #105. Resident #002 was walking along the same corridor and suddenly resident #002 displayed a responsive behavior. Resident #001 immediately moved towards resident #002 and pushed the resident to the floor which caused an identified injury.

During an interview, registered staff RPN #107 and #104 stated resident #001 was often involved in physical altercations with staff and co-resident more often during the evening shifts. RPN #107 further stated that staff working the evening shifts tried to monitor resident #001; but had limited resources since they were required to provide care for 24 residents. RPN #107 also stated resident #001 should be referred to an external specialized team for assessment and treatment. The RPN further stated the referral was outside of their scope but that they had passed the information to the home's internal team for an assessment.

During an interview, the home's internal assessment team RPN #102 and Social Worker (SW) #103 stated they were in communications with resident #001's power of attorney (POA) regarding a referral to an external resource team to support the resident; and also expressed the need for a specific intervention to support the resident during the evening hours. However, the resident's POA declined referral and change in intervention. RPN #102 and SW #103 verified during the interview that they did not discuss the POA's decline of both suggested interventions with their internal management team to facilitate support and further communications with the POA.

During an interview, the Director of Resident Care stated the expectation was that the assessment team identify the level of risk or gaps in care beyond their scope; follow the home's Protocol and refer the resident to external resources; and communicate with the management team so that they could collaborate and provide support required to address residents' care needs. The DRC verified that they were not aware of the number of incidents involving this resident until they reviewed the progress notes after the incident; and they were not aware that the internal assessment team had suggested a change of interventions to the POA prior to the incident.

Therefore, the home failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The Ministry of Health (MOH) received a critical incident on an identified date related to responsive behaviors.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date to have responsive behaviors.

During separate interviews, registered staff RPN #104 and #107 verified that resident #002 behaviors were assessed; and that resident #002 never experienced such incidents with other residents on the unit until recent incidents with resident #002. Both staff further verified that resident #002's behavior provoked both altercations since resident #001 was sensitive to that trigger. However, neither staff recalled referring resident #002 to the home's internal assessment team to support assessment, identification of triggers and interventions.

During an interview, RPN #102 verified that resident #002 was not referred to the internal assessment team by registered staff to support the identification of triggers and development of a comprehensive treatment plan. Therefore, the licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complementary to each other. [s. 6. (4) (a)]

WN #4: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure where an incident occurred that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health status; contact the hospital within three calendar days after the occurrence of the incident; and where the licensee determines that the injury has resulted in a significant change in the resident's health status, inform the director of the incident no later than three business days after the occurrence of the incident, and follow with the required report.

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001’s responsive behavior which resulted in resident #002 sustaining an injury.

A review of the critical incident indicated and interviews with registered staff RPN #104 and private companion #105 verified that on an identified date, resident #001 pushed resident #002 to the floor which resulted in an injury for which the resident was transferred to acute care hospital for assessment and treatment.

During an interview, DRC #100 verified that they were aware the resident sustained an injury and required a procedure on a later day; however the critical incident was reported to the Director outside the reporting period. The DRC also informed the inspector that they were unsure of the timeline to report the critical incident. However, after reviewing the regulation, the DRC verified that the incident should have been reported to the Director no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 18th day of December, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

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

Ministère 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) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2018_324535_0013
Log No. / No de registre :	028528-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 10, 2018
Licensee / Titulaire de permis :	The Kensington Health Centre 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
LTC Home / Foyer de SLD :	The Kensington Gardens 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William O'Neill

To The Kensington Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA, 2007.

Specifically the licensee must do the following:
- ensure all management and staff are aware of what constitutes physical abuse; and document what was communicated to who and by whom.
- ensure that resident #002 and any other vulnerable residents are protected from abuse by resident #001. Develop an assessment/monitoring tool that is shared with direct care staff as appropriate.

Grounds / Motifs :

1. The licensee has failed to ensure resident #001 was protected from abuse by anyone.

Ontario Regulation 79/10, s. 2 (1) (c) indicated physical abuse means the use of physical force by a resident that causes physical injury to another resident.

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001's responsive behavior which caused resident #002 to sustain an injury for which they were transferred to the hospital and had a procedure.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date to have responsive behaviors.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date to have identified responsive behaviors as

well.

Record review of the progress notes indicated, and interview with registered staff RPN # 104 verified, that on an identified date and time, a personal care associate (PCA) was accompanying resident #001 and #002 to the dining room. However, resident #002 started displaying a responsive behavior; and that immediately prompted resident #001 to reach over to push resident #002; however the PCA intervened and resident #002 was not harmed during the altercation.

Record review of the critical incident indicated, and interviews with registered staff RPN #104 and private companion #105, verified that on an identified date and time, resident #001 was walking in the corridor, accompanied by private companion #105. Resident #002 was walking along the same corridor; then resident #002 suddenly had an identified responsive behavior and resident #001 immediately lunged towards resident #002 and pushed the resident causing them to experience a fall to the floor with an injury. During the interview, private companion #105 stated that they attempted to separate both residents but was pushed aside by resident #001.

Record review indicated resident #001 remained calm for the rest of the shift. However, resident #002 was transferred to the acute care hospital where they were diagnosed with an injury which required a procedure.

During an interview, DRC #100 verified that after the incident occurred, the home initiated a specific strategy to support resident #001 during the evening shift in addition to the intervention already implemented during the day shift. The progress notes indicated that on an identified date, the home's internal assessment team accompanied resident #001 to the acute care hospital for an assessment; and specific a treatment was recommended and implemented.

DRC #100 verified during an interview that they were not aware of the number of incidents involving resident #001 until they read the progress notes. DRC #100 also stated the gap in care was that the level of risk was not identified by the team. Furthermore, DRC #100 stated they viewed the incident differently although the incident resulted in an injury. The incident was not reported to the Director as abuse. According to the DRC, there was no intent to harm since they

both did not understand the circumstance of their actions; hence the situation was not thought of as abuse. During the interview, the inspector explained the licensee's duty to protect residents from abuse by anyone under s. 19 (1) of the LTCHA, 2007; and the DRC acknowledged they understood the reasoning. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level one as it was related to one resident. The compliance history indicates one or more unrelated non-compliance in the last 36 months. Due to the actual harm of a resident by another resident with the use of physical force, a compliance order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54 of the regulation.

Specifically, the licensee must do the following:
- ensure resident #001 and #002 receive a responsive behavior assessment from the homes BSRT lead.
- ensure that the recommended interventions are implemented as approved by the physician in a timely manner.
- ensure that residents #001 and #002 and other applicable residents' responsive behavior triggers are identified and reviewed by the home's BSRT.

Grounds / Motifs :

1. The licensee has failed to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The Ministry of Health (MOH) received a critical incident on an identified date, related to resident #001's responsive behavior which caused resident #002 to sustain an injury.

Record review indicated resident #002 was assessed using the quarterly Minimum Data Set (MDS) assessment tool on an identified date, and indicated to have identified responsive behaviors.

Record review indicated resident #001 was assessed using the quarterly MDS assessment tool on an identified date; and indicated to have identified responsive behaviors.

On an identified date, the inspector observed the location of both residents' rooms along the back corridor on the unit. Record review indicated, and staff interviews verified that both residents resided in the same corridor; and their paths could cross on the unit.

A review of resident #001 identified assessment tool on a specific date indicated behaviors of concern. A review of the resident's written care plan indicated that on an identified date, an entry was made indicating the resident's responsive behavior triggers.

A review of the critical incident indicated, and interviews with registered staff RPN #104 and private companion #105 verified that resident #001 exited their room and was walking in the corridor with the private companion #105. Resident #002 was walking along the same corridor and suddenly resident #002 displayed a responsive behavior. Resident #001 immediately moved towards resident #002 and pushed the resident to the floor which caused an identified injury.

During interviews, the home's internal assessment team Co-Leads RPN #102 and SW #103 verified they were aware of resident #001 responsive behaviors; resident #002 responsive behaviors; and that both residents walked in the same corridor; however, they never thought of relocating one resident to another area of the unit to reduce the risk of their paths crossing which could potentially cause harmful interactions.

During an interview, the DRC verified that in the past, they had discussions with resident #001's POA related to transferring the resident to another area in the home and transferring the resident to another secured unit in the home. However, there were no beds available and both units also had vulnerable residents and were therefore not suitable. There was no indication the team discussed relocating resident #002 to another secured area of the home to eliminate the risk of altercation and potential harmful interactions given both

residents identified responsive behaviors and resident #001 identified trigger.

Therefore, the home failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions to separate both residents. [s. 54. (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level one as it was related to one resident. The compliance history indicates one or more unrelated non-compliance in the last 36 months. Due to actual harm of a resident during the responsive behavior altercation, a compliance order is warranted. (535)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 10th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Veron Ash

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