Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 23, 2016	2016_298557_0004	023482-15, 033990-15	Critical Incident System

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

VALERIE PIMENTEL (557)

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): February 8, 9, 10, 11, 12, 16, 17 and 18, 2016.

The following Critical Incidents were inspected: Intake Log #033990-15 related to a fall with injury and Log #023482-15 related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Program Manager (PM), Case Manager (CM), Physician, Physio Therapist (PT), Physio Therapist Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Substitute Decision Makers (SDM).

The inspector observed staff and resident interactions, observations of the home areas and tub/shower room, record review of resident and home records, education records and reviewed relevant policy and procedures related to the inspection.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect the resident from physical and emotional abuse by anyone.

Under Ontario Regulation 79/10 the "Abuse" — definition is as follows: for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "Physical abuse" means: the use of physical force by anyone other than a resident that causes physical injury or pain. Emotional abuse means: any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In August 2015, the home submitted a critical incident report (CI), involving resident #001. The CI indicated resident #001 was repositioned in bed by a staff member that resulted in the resident experiencing pain.

On February 8, 2016, the inspector interviewed resident #001, the resident retold the incident that occurred in August of 2015. The resident stated a staff member repositioned him/her in bed in a manner that caused pain. During the repositioning the staff member spoke abruptly to the resident and demanded the resident get out of bed. Resident #001 was upset at the manner he/she was treated. Resident #001 confirmed the incident did occur and recalled the incident verbatim as from the home's reports. When asked if he/she spoke with anyone about the incident, the resident said he/she spoke to the PM, DOC and the ED.

Record review of resident #001's plan of care, including progress notes, 24 hour report and the nursing report confirmed an incident did occur. A review of the home's investigation notes, including a written statement from resident #001 were reviewed and confirmed the incident did occur.

An interview with the PM and DOC confirmed resident #001 spoke with them after the incident occurred and the home initiated an investigation.

The licensee implemented disciplinary measures after the conclusion of the home's investigation.

Staff interviews with the DOC and ED confirmed the home failed to protect resident #001 from both physical and emotional abuse.

The severity of harm was physical and emotional abuse to resident #001 by the staff member, as a result, resident #001 sustained physical pain and or discomfort and

emotional abuse as resident #001 had full recall of the incident and was upset at the manner he/she was treated. The scope was isolated. [s. 19. (1)]

2. The licensee failed to ensure that residents are not neglected by the licensee or staff.

Under Ontario Regulation 79/10, subsection 5 the "Neglect" — definition is as follows: "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In November 2015, the home submitted a critical incident report (CI), involving resident #002. The CI identified that resident #002 asked an identified staff member to remove his/her lap belt as he/she was cold, the staff member turned to get another towel for the resident. In the time the staff member turned and reached for the towel the resident fell from an identified piece of equipment onto the floor.

Record review of resident #002's progress notes, post-fall huddle notes and the CI revealed the identified staff member did provide care to resident #002 on an identified home area. During the provision of care resident #002 stated he/she was cold and asked the staff member to release the safety strap and the support bar from the identified piece of equipment because the resident was uncomfortable. Resident #002 fell to the floor while assisting with his/her care.

The resident sustained several injuries as a result of the fall.

An interview with the identified staff member confirmed the incident did occur as described and further confirmed there was no other staff present at the time of the incident. An interview with another staff member confirmed resident #002 sustained injuries.

The home's policy LTC Resident Care, titled Resident Transfer and Lift Procedures, Policy #VIIG-20.20(k), dated July 2015, identifies the following: to follow the manufacturer's instructions for the safe operation of the identified piece of equipment, a second person must be in attendance when using the identified piece of equipment to transfer and at no time is it permissible for one staff member to operate the identified piece of equipment.

The home's policy LTC Resident Care, titled Prevention of Abuse and Neglect of a

Resident, Policy #VII-G-10.00, dated January 2015, includes improper or incompetent treatment or care of a resident that results in harm of a resident as part of their abuse policy.

Interviews with the ADOC and DOC confirmed the home did not protect resident #002 from neglect, the resident was not provided care consistent with the home's policy. The resident was not protected from injury and the identified staff member neglected to leave the safety belt intact and the arm support bar.

The severity of harm was actual harm to resident #002, the staff member failed to leave safety devices intact and have a second person in attendance while operating an identified piece of equipment. The scope was isolated. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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 home failed to ensure that the following are documented - the provision of the care sets out in the plan of care.

Record review of resident #002's plan of care revealed the resident is to receive an anlagesic, three times a day. Review of the electronic medication administration record (eMAR's) revealed on January 7, 8, 11, 12, 14, 25, 26, 27, 30 and 31, 2016, at 1:30 PM, the MAR' s were not signed by the identified staff member as having administered the analgesic to the resident.

The home's policy in MediSystem Pharmacy Manual, Subject: Medication Pass – Procedure, Index Number: 04-02-20, last reviewed: June 23, 2014, indicates to initial the eMAR at the time of administration.

Interviews with two DOC's confirmed that identified staff member did not document in the eMAR's the administration of resident #002's analgesic as set out in the plan of care. [s. 6. (9) 1.]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Resident #002 fell on an identified date and was sent to hospital for assessment. The resident was diagnosed with several injuries. The resident was seen in the emergency department and returned to the home with the following directions: to have the two identified body parts buddy taped with Coban daily for approximately eight weeks. The home's physician approved this order on an identified date. The treatment should have been assessed and or discontinued on another identified date at the end of an eight week period.

The inspector observed after the eight week period that resident #002's, two identified body parts had Coban tape intact.

Record review of the resident's plan of care revealed in the physio task sign off sheet that an identified staff member was still applying the Coban tape as noted on the identified date.

An interview with the an identified staff member confirmed that he/she had not transcribed the intervention into the plan of care nor had he/she made a note to assess the resident at the end of the eight week time frame. An interview with two other identified staff members confirmed that no notation had been made for nursing or the

physician to assess the resident's identified body parts at the end of the eight week time frame. One of the identified staff members was asked how this was done he/she indicated that a note is put onto the daily clip board for the physician. When asked about this further, since it is a daily note, how would the staff remember for eight weeks in time, the response was it would be put in the floors daily journal. The journal was reviewed with both the identified staff members and no notation to assess resident #002's identified body part on an identified date was found.

The PT and DOC confirmed the plan of care for resident #002 was not reviewed or revised to include interventions and assessments. [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 that the following are documented, the provision of the care set out in the plan of care and 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 the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The home's policy LTC Resident Care, titled Prevention of Abuse and Neglect of a Resident, Policy #: VII-G—10.00, dated January 2015, identifies the home to document the current status in the resident's record and to assess his/her safety, emotional and physical well-being.

Record review of the resident's plan of care and the progress notes for an identified date, failed to reveal any documentation that a physical assessment was completed for resident #001 to identify any injury when he/she informed the PM that he/she had been hurt by an identified staff member.

A staff interview with the DOC confirmed the home did not follow the policy and document the current status of the resident on the identified date. [s. 8. (1) (b)]

2. The home's policy LTC Resident Care, titled Resident Transfer and Lift Procedures, Policy #: VIIG-20.20(k), dated July 2015, identifies the following; to follow the manufacturer's instructions for the safe operation of an identified piece of equipment, a second person must be in attendance during the transfer and at no time is it permissible for one staff member to operate an identified piece of equipment.

Record review of the CIS #2819-000045-15, and Falls Incident Report-Post Fall Huddle assessment revealed an identified staff member undid resident #002's safety seat belt on an identified piece of equipment and did not have a second staff member in attendance when using the identified piece of equipment.

An interview with the identified staff member confirmed he/she did undo the safety seat belt on an identified piece of equipment and confirmed there was not a second staff member present when using the identified piece of equipment.

An interview with ADOC and DOC confirmed the staff member did not follow the home's policy and it is an expectation that all staff follow the home's policy to ensure the safety of all residents by having two staff present when using the identified piece of equipment. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance policy, protocol, procedure, strategy or system is complied with: to ensure residents are assessed and the documentation of the assessment is recorded, and that two staff been in attendance for all transfers using identified equipment, to be implemented voluntarily.

WN #4: 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 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: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Record review of a Critical Incident, with an allegation of improper care was initiated on an identified date and not submitted to the Director until three days after the incident occurred.

Interviews with the DOC and ED confirmed the home did not notify the Director immediately as the incident did occur and the incident was a result of improper or incompetent care that resulted in harm to the resident. [s. 24. (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 when the licensee 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: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On an identified date, the home submitted a critical incident report (CI), in respect to resident #002. The staff member did not have another staff member assisting him/her during the transfer of resident #002.

The home's policy LTC Resident Care, titled Resident Transfer and Lift Procedures, Policy #: VIIG-20.20(k), dated July 2015, identifies the following: to follow the manufacturer's instructions for the safe operation of an identified piece of equipment, a second person must be in attendance during the transfer and at no time is it permissible for one staff member to operate the identified piece of equipment.

The resident complained to to the staff member that he/she was cold because the safety belt was wet. The staff member removed the safety belt from around the resident's abdomen and raised the arm support bar. The staff member turned to reach for a towel and the resident fell onto the floor.

The resident sustained several injuries.

An interview with the identified staff member confirmed he/she was without a second staff member when he/she transferred the resident.

An interview with the identified staff member, ADOC and DOC confirmed the staff member did not use safe transferring and positioning techniques when assisting resident #002 and did not follow the home's policy. [s. 36.]

Additional Required Actions:

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

Issued on this 15th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2016_298557_0004
Log No. / Registre no:	023482-15, 033990-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 23, 2016
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

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 :

Upon receipt of this order the licensee shall:

1. The licensee shall provide a plan to the inspector on how the home will ensure that no resident will be physically and emotionally abused by the licensee or staff.

2. The licensee shall provide a plan that includes how staff will be educated, the type of education that they receive in reference to abuse, neglect and retaliation and the contents of education to be included.

3. The licensee shall provide education for all nursing staff and those staff members from other disciplines that are or may be required to use transfer equipment to assist residents, to include but not inclusive to safe lift and transferring techniques.

4. Minutes and attendance to be documented and forwarded to valerie.pimentel@ontario.ca

5. The plan(s) shall include time lines and the name of the person(s) responsible for completing the tasks and the time lines for completion. The plan shall be submitted on or before August 31, 2016, to valerie.pimentel@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

Under Ontario Regulation 79/10, subsection 5 the "Neglect" — definition is as

follows: "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In November 2015, the home submitted a critical incident report (CI), involving resident #002. The CI identified that resident #002 asked an identified staff member to remove his/her lap belt as he/she was cold, the staff member turned to get another towel for the resident. In the time the staff member turned and reached for the towel the resident fell from an identified piece of equipment onto the floor.

Record review of resident #002's progress notes, post-fall huddle notes and the CI revealed the identified staff member did provide care to resident #002 on an identified home area. During the provision of care resident #002 stated he/she was cold and asked the staff member to release the safety strap and the support bar from the identified piece of equipment because the resident was uncomfortable. Resident #002 fell to the floor while assisting with his/her care.

The resident sustained several injuries as a result of the fall.

An interview with the identified staff member confirmed the incident did occur as described and further confirmed there was no other staff present at the time of the incident. An interview with another staff member confirmed resident #002 sustained injuries.

The home's policy LTC Resident Care, titled Resident Transfer and Lift Procedures, Policy #VIIG-20.20(k), dated July 2015, identifies the following: to follow the manufacturer's instructions for the safe operation of the identified piece of equipment, a second person must be in attendance when using the identified piece of equipment to transfer and at no time is it permissible for one staff member to operate the identified piece of equipment.

The home's policy LTC Resident Care, titled Prevention of Abuse and Neglect of a Resident, Policy #VII-G-10.00, dated January 2015, includes improper or incompetent treatment or care of a resident that results in harm of a resident as part of their abuse policy.

Interviews with the ADOC and DOC confirmed the home did not protect resident

#002 from neglect, the resident was not provided care consistent with the home's policy. The resident was not protected from injury and the identified staff member neglected to leave the safety belt intact and the arm support bar.

The severity of harm was actual harm to resident #002, the staff member failed to leave safety devices intact and have a second person in attendance while operating an identified piece of equipment. The scope was isolated. (557)

2. The licensee failed to protect the resident from physical and emotional abuse by anyone.

Under Ontario Regulation 79/10 the "Abuse" — definition is as follows: for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "Physical abuse" means: the use of physical force by anyone other than a resident that causes physical injury or pain. Emotional abuse means: any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In August 2015, the home submitted a critical incident report (CI), involving resident #001. The CI indicated resident #001 was repositioned in bed by a staff member that resulted in the resident experiencing pain.

On February 8, 2016, the inspector interviewed resident #001, the resident retold the incident that occurred in August of 2015. The resident stated a staff member repositioned him/her in bed in a manner that caused pain. During the repositioning the staff member spoke abruptly to the resident and demanded the resident get out of bed. Resident #001 was upset at the manner he/she was treated. Resident #001 confirmed the incident did occur and recalled the incident verbatim as from the home's reports. When asked if he/she spoke with anyone about the incident, the resident said he/she spoke to the PM, DOC and the ED.

Record review of resident #001's plan of care, including progress notes, 24 hour report and the nursing report confirmed an incident did occur. A review of the home's investigation notes, including a written statement from resident #001 were reviewed and confirmed the incident did occur.

An interview with the PM and DOC confirmed resident #001 spoke with them after the incident occurred and the home initiated an investigation.

The licensee implemented disciplinary measures after the conclusion of the home's investigation.

Staff interviews with the DOC and ED confirmed the home failed to protect resident #001 from both physical and emotional abuse.

The severity of harm was physical and emotional abuse to resident #001 by the staff member, as a result, resident #001 sustained physical pain and or discomfort and emotional abuse as resident #001 had full recall of the incident and was upset at the manner he/she was treated. The scope was isolated. (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Pimentel

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