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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_536537_0035	012053-17, 012057-17	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

Mount Hope Centre for Long Term Care
21 GROSVENOR STREET P.O. BOX 5777 LONDON ON N6A 1Y6

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

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, 27, 28, 29 and October 3, 2017

The following intakes were inspected during this inspection:
Log #012053-17
Log #012057-17

A Written Notification (WN) and Compliance Order related to LTCHA, 2007 c.8, s.6(7) identified in inspection #2017_536537_0037, inspection #2017_536537_0036 and inspection #2017_536537_0038, will be issued in this report.

A Written Notification (WN) and Compliance Order related to LTCHA, 2007 c.8, s.6(10)(b) identified in inspection #2017_536537_0036 and inspection #2017_536537_0037, will be issued in this report.
A Written Notification (WN) and Compliance Order related to LTCHA, 2007 c.8, s.19(1) identified in inspection #2017_536537_0036, will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Interim Directors, Coordinator St Mary's (SM), Coordinator Marian Villa (MV), Point Click Care (PCC) Support, Administrative Assistant, Quality Project Lead, Director of Facilities Management (DOFM), Long Term Care Support (LTC) St Mary's, Long Term Care Support (LTC) Marian Villa, Registered Dietitian (RD), Coordinator Dietary, Manager Resident Services Sienna, Resident Assessment Instrument (RAI) Consultant, Human Resources Manager Medical Priorities, Coordinator Medical Priorities, Staff Educator, Scheduling Lead, Privacy Consultant St. Josephs, Detective London Police Services, Pharmacist, Bellwright, five Registered Nurses (RN), 16 Registered Practical Nurses (RPN), 34 Personal Care Providers (PCP), one Personal Care Assistant (PCA), one Housekeeping Aide, one Dietary Aide, one Therapeutic Recreation Aide, families and residents.

The inspector(s) also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed assessments, various policies and procedures of the home, training records and the home's internal plans, reviewed various meeting minutes, and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Responsive Behaviours
Safe and Secure Home

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

- **4 WN(s)**
- **0 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 10. (1)	CO #003	2016_457630_0045	658
O.Reg 79/10 s. 17. (1)	CO #004	2016_457630_0045	630
O.Reg 79/10 s. 53. (1)	CO #006	2016_457630_0045	630
O.Reg 79/10 s. 53. (4)	CO #007	2016_457630_0045	630
O.Reg 79/10 s. 68. (2)	CO #009	2016_457630_0045	630
O.Reg 79/10 s. 91.	CO #008	2016_457630_0045	658

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. 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 home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #005, the licensee was ordered to take action to achieve compliance by ensuring that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff. This order was to be complied with by June 30, 2017.

Inspector's #658 and #630 toured Marian Villa to observe the resident-staff communication and response system.

On Marian Villa Fifth Floor, it was observed that the call signalling from a resident room was audible when standing near the resident-staff communication and response system at the nursing station and when standing close to the black phone in the hallway. It was observed that the call signal was not audible towards the end of the hallway past the identified room or in the resident rooms.

A Registered Nurse (RN) told the inspectors that staff would know that a resident had activated the resident-staff communication and response system by the light outside the room as well as the intercom at the nursing station and the phones in the hallways. The RN said the home did not use pagers as part of the system. The RN said that the phones in the hallways were now locked in a box mounted on the wall. The inspectors activated the call response system in the presence of the RN and this staff member acknowledged that it was not audible towards the end of the hallway or from within the identified room. The RN said that this was the first time they had become aware that the resident-staff communication and response system was not audible in that area.

On Marian Villa Fourth Floor, it was observed that the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in the hallway outside the room or in the resident rooms.

A Personal Care Provider (PCP) responded to the resident-staff communication and response system for the room and said they had been notified by the light in the hallway. During this interview, the inspectors could not hear the resident-staff communication and response system when standing in the hallway and in the room while the PCP said that they could hear the system.

On Marian Villa Second Floor, it was observed that the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in other rooms on the unit. It was also observed that the resident-staff communication and response system was not audible from within the dining room.

A PCP, while in the dining room, acknowledged to the inspectors that they could not hear the resident-staff communication and response system in that area. A PCP said that there were other areas where staff could not hear the system such as in resident rooms when providing care and when in the report room.

On Marian Villa First Floor, it was observed the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in the hallway, even when standing in front of the phone, or in the resident room.

A PCP acknowledged to the inspectors that they could not hear the resident-staff

communication and response system in the hallway. A PCP said that usually they would hear the system from the phone in the hallway but that phone was not working at the time of observation. A PCP said that apart from the intercom at the nursing station and the phones in the hallway they did not have another means to hear the system.

Inspector's #658 and #630 toured Marian Villa with Coordinator Marian Villa (MV) . Coordinator MV said that although they were aware of the home's plan regarding the compliance orders related to the resident-staff communication and response system, it was the former Director and the Director of Facilities Management (DOFM) who had been the most involved addressing this issue. Coordinator MV said the staff relied on the auditory part of the system from the intercom at the nursing station and the phones in the hallways. During this tour, Coordinator MV acknowledged that the resident-staff communication and response system was not audible to staff in all areas of the home. During the tour, it was observed that the system was not audible in several areas on multiple floors of Marian Villa.

The Director of Facilities Management (DOFM) told Inspector's #658 and #630 they were familiar with the Compliance Order (CO) related to the resident-staff communication and response system and the home's compliance plan that was created. When asked what changes had been made in the home related to CO #005, DOFM said that previously the issue had been that the phones in the hallways were being turned down by staff and could not be heard from all areas. DOFM said in response to the CO they turned the phones to maximum volume and then closed them into a box. DOFM said there was no way for staff to turn down the volume on the phones unless they accessed them by a key. When asked what was done after the boxes were put on the phones to check on whether they were audible, DOFM said they had not heard of any problems since the changes were made and the staff never brought forward any concerns.

Inspector's #658 and #630 toured Marian Villa with DOFM . During this tour, DOFM acknowledged that the resident-staff communication and response system was not audible to staff in all areas of the home. During the tour, it was observed that on Marian Villa, the system was not audible in several areas. DOFM also said that the covers over the phones were just an interim solution. At the end of the tour, DOFM said they were going to have a staff member go around and recalibrate all alarms including at the nursing station and also planned to have staff check the resident-staff communication and response system regularly.

The Quality Project Lead said that as part of the response to CO #005, the home had

started doing "Management By Walk About" (MBWA) audits. Quality Project Lead said as part of the MBWA audits, the management in the home had been checking on the resident-staff communication and response system. They said that the audits had focused on the audibility of the system at times but the main focus had been on staff response time. Inspector #630 reviewed the MBWA audits forms with Quality Project Lead and they identified that there had been an audit which documented that the "volume was low" on the phone on Marian Villa Fifth Floor. Quality Project Lead said they spoke with staff at the time and they said that they could hear it. Quality Project Lead said the management team completed a "MBWA Weekly Review" where they discussed issues that were identified during the audits. They said that the audibility of resident-staff communication and response system in Marian Villa had not been identified or discussed as a concern at these meetings. Quality Project Lead said that they were planning to have more focus during the audits for this issue.

Inspector #630 toured Marian Villa to observe the resident-staff communication and response system. During this tour, it was observed that on Marian Villa Fourth Floor the system was not audible in the resident lounge and in the hallway and on Marian Villa First Floor, the system was not audible in the hallway During this tour, a PCP acknowledged to Inspector #630 that the resident-staff communication and response system on Marian Villa First Floor could not be heard in the hallway outside of an identified room 112 and said that they heard the home was in the process of addressing this issue.

A resident , who lived in Marian Villa , told Inspector #630 that they had noticed that the resident-staff communication and response system in their room and bathroom did not make a sound when they activated it for assistance. The resident asked Inspector #630 if this was going to be repaired as they had concerns about the system particularly when they were in the bathroom. The resident said that sometimes they had to wait for assistance from staff after activating the system in the bathroom.

DOFM told Inspectors #658 and #630 that it was the expectation that the call response system would have a level of sound that was audible to staff in all areas of the home, including the hallways and dining rooms in Marian Villa.

Based on these observations and interviews, the licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff in Marian Villa.

The severity level was determined to be level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 12, 2016 in the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 17. (1) (g)]

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. 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #002, the licensee was ordered to take action to achieve compliance by ensuring that the home's written policy to promote zero tolerance of abuse and neglect was complied with. This CO also stated that the licensee was to also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure that all staff were educated on the home's policy including reporting mechanisms and that there was a monitoring process in place to ensure that the home's abuse policy was implemented. The education and training provided to all staff was to include re-education regarding sexual abuse. This education was to address consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot

consent to these sexual activities. This order was to be complied with by August 31, 2017 .

The home's policy "Abuse and Neglect of Residents: Zero Tolerance" with "Revised Date September 27, 2016" and "Reviewed Date November 8, 2016" included the following procedures:
- 1.2.2. "Staff education and training will include:
a) policy and procedures for zero tolerance of abuse and/or neglect including definitions of abuse and neglect and use of Ministry of Health and Long Term Care (MOHLTC) Licensee Reporting of Abuse Decision Tree;
b) policy and procedures on reporting of inappropriate activities (i.e. whistle blowing) and protection from retaliation"

Section 2(1) of the Long Term Care Homes Act 2007 defined "staff" in relation to a long-term care home as "persons who work at the home as employees of the licensee, pursuant to a contract or agreement with the licensee or pursuant to a contract or agreement between the licensee and an employment agency or other third party."

A caregiver was observed working with a resident. During an interview, the caregiver stated that they worked in the home through an agency as a companion to a resident every day, and that they had been doing this for about a year.

During an interview, the caregiver told an inspector that they did receive orientation from the agency they were employed by prior to starting but said this did not include education on Mount Hope's written policy on the prevention of abuse or neglect or the process for reporting abuse. When asked if the home had provided any training regarding prevention of abuse, including sexual abuse, the caregiver said they had not participated in this type of education.

Human Resources (HR) Manager for the agency told Inspector #630 that they had Personal Support Workers (PSWs) who worked at Mount Hope as one to one companions as well as in any Personal Care Provider (PCP) shifts. When asked about training that was provided to the staff, HR Manager said that when they were hired they received orientation from the agency and education on their internal policies. When asked if their staff received training on the Mount Hope policy on prevention of abuse and neglect they said the agency staff had not been trained on this policy. When asked if the agency staff participated in classroom training or orientation when they started working at Mount Hope from the home, HR Manager said they did not participate in that education.

When asked if any of the agency staff received training on abuse from Mount Hope, they said that the staff did not receive this education. When asked how many staff they had working at Mount Hope, they said they did not know but would find out.

Coordinator MV told Inspector #630 that the caregiver worked for an agency and did not receive training from Mount Hope regarding the home's written policy and procedures on prevention of abuse and neglect. When asked about the education provided to staff working through agencies in general, Coordinator MV said that she was not sure if the companies have received education packages but could find out from Staff Educator. When asked about the orientation these staff received when they started working at Mount Hope, Coordinator MV said they had a booklet on the unit that outlined their duties and information on the resident but they did not participate in classroom training as the education was provided to them through the agency. During the interview Coordinator MV called Staff Educator and was told that the staff from the agency did not receive training within the home including the training that was done in the summer on prevention of abuse and neglect and sexual abuse or the responsive behaviours program.

The Staff Educator told Inspector #630 that the education provided to PSWs working in the home through agencies differed depending on the agency. Staff Educator said that staff working through one agency employed by the home had to complete education provided through their agency which included an orientation package provided by Mount Hope prior to working in the home. Staff Educator said this education included information about the home's written policy on the prevention of abuse and neglect. When asked if this education addressed consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including consent, Staff Educator acknowledged that it did not. Staff Educator said that none of the PSWs working through agencies participated in the education provided to staff on sexual abuse. Staff Educator said that the PSWs working for two other outside agencies did not receive education on Mount Hope's written policy on prevention of abuse and neglect or the recent education on sexual abuse.

Scheduling Leader said that PSWs from the three outside agencies employed by the home were scheduled for shifts at Mount Hope either as caregivers or in PCP shifts. Scheduling Leader identified a total of 96 shifts worked by agency staff in a specific18 day time frame.

A caregiver said that they had been working at Mount Hope through an agency for about two and a half years. The caregiver said that they thought they had received education

on prevention of abuse and neglect about two and half years ago but did not recall education about the Mount Hope policy on prevention of abuse and neglect. The caregiver said that they had not recently received education regarding prevention of abuse or sexual abuse when it was presented to Mount Hope staff.

HR Manager of a specific agency told Inspector #630 that they had 54 PSW staff who had been working at Mount Hope.

Coordinator MV said it was the expectation in the home that all staff would comply with the home's written policy on the prevention of abuse and neglect which included procedures on staff education and reporting of alleged abuse or neglect.

Coordinator MV said it was the expectation in the home that all staff, including staff working through agencies, received education on the home's policy on the prevention of abuse and neglect and as per CO #002 re-education regarding sexual abuse which addressed consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities. Coordinator MV acknowledged that this education was not provided to all staff of the home.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 7, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_260521_0057, on January 7, 2016, in a Complaint Inspection #2016_260521_0002 as a VPC, on May 26, 2016, in Critical Incident Inspection #2016_226192_0022 as a Compliance Order (CO) and a Director's Referral (DR), on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC and on December 12, 2016 during the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 20. (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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Section 2(1) of Ontario Regulation 79/10 defined emotional abuse as 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.

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

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order #001, the licensee was ordered to take action to achieve compliance by ensuring that all residents were protected from abuse by anyone and that residents are not neglected by the licensee or staff. This CO also stated that the licensee was also to ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure that all staff were to be provided education and training that included the home's policy to promote zero tolerance of abuse. The licensee would monitor, evaluate and adapt their compliance plan to ensure all residents would be protected from abuse and neglect. This order was to be complied by August 31, 2017.

A Critical Incident System (CIS) report submitted by the home identified potential staff to resident abuse, as reported by the family of a resident. The report stated that the family had concerns with regards to care they had observed, involving several staff. The family submitted a MOHLTC Infoline regarding the same concerns and allegations.

Interview with the family was conducted who shared what they had observed and their

concerns.

The care plan for the identified resident indicated specific interventions in place to ensure care was provided in a manner consistent with identified medical concerns, personal preferences, and assessed care needs.

a) Inspector #537 reviewed the care provided during three specified time periods which identified potential abuse to a resident by staff members.

During an interview with an identified staff member, they stated that they were aware of the allegations that had been raised and stated that they did not feel the accusations were accurate. The staff member did state that they had provided care that was not consistent with the needs and preference of the resident, and that their conversation with the resident was not intended to be degrading or to minimize the feelings of the resident. The staff member stated that the actions were completed to ensure the care was completed before the end of shift.

During an interview with another identified staff member, they acknowledged that they had not provided care safely as per the assessed needs of the resident and as per their personal needs and preferences.

During an interview with an additional identified staff member, they acknowledged that they were aware that there had been allegations raised regarding their conduct in providing care to the identified resident, but denied that they had any recollection of any of the incidents that were alleged.

Coordinator St Mary's (SM) stated that they were aware of the observations made and the concerns of the family and that the actions, and verbalizations of the staff was inappropriate and not what was expected of staff to residents, and implemented their own internal processes to address the staff member involved.

The licensee has failed to protect a resident from abuse.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of this legislation being issued in the home on May 26, 2016, in Critical incident Inspection #2016_226192_0022 as a Director's Referral (DR), on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO), and on December 12,

2016in the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to the resident as specified in the plan.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #010, the licensee was ordered to take action to achieve compliance by ensuring the care set out in the plan of care was provided to the resident as specified in the plan, for all residents. The licensee was also to ensure that there was a system in place to monitor that the care set out in the plan of care was being provided to residents as specified in the plan including who would be responsible for monitoring. This order was to be complied with by June 30, 2017.

A) An inspector observed a resident in the dining room during a meal. The resident had multiple food items in front of them. The resident was observed to be eating and drinking very little during the meal. Not all items as identified in the plan of care for this resident

for eating were observed to be in use.

Review of the clinical record for the resident showed care plan interventions that included use of specific devices and techniques to be used during meal service, based on assessment of the resident and family requests.

The Registered Dietitian (RD) told Inspector #630 that the resident generally ate poorly and the family had been quite concerned.The RD said that if the plan of care identified that specific interventions were required to support food and fluid intake then it would be up to the nursing staff to ensure that this was done at meals, and that all identified interventions should be used.

Inspector #630 observed the identified resident in the dining room during another meal service. The resident again had multiple items in front of them, contrary to the plan of care, as well as specific devices not being used. The resident was again observed to be eating and drinking very little during the meal. Part way through the meal a caregiver was observed in the dining room assisting the resident with the meal through verbal and physical cues. Inspector #630 then spoke with an RPN regarding the plan of care for "eating" and "nutritional status" compared to the care being provided to the resident during the meal service. The RPN acknowledged that the care being provided to the resident did not match the plan of care.

The caregiver told Inspector #630 that they were assigned to the resident for the day shift and this was their first time working with this resident. When asked how they found out about the resident's care needs they said they looked at the "caregiver plan of care: expectations and interventions" booklet in the resident's room. Inspector #630 reviewed the plan of care in this booklet with the caregiver and it was identified that this plan of care stated that the caregivers were not to be providing any personal care for the resident including assistance at meals. The caregiver acknowledged that they had been assisting the resident in the dining room with their meal and that they were not aware of the contents of the plan of care in Point Click Care (PCC) related to eating assistance or nutritional status as they did not review these prior to the shift.

Coordinator MV told Inspector #630 that it was the expectation in the home that staff would provide care to the resident as per the plan of care. Reviewed the plan of care in PCC and the "caregiver plan of care: expectations and interventions" and Coordinator MV said that it was the expectation caregivers were not to be providing assistance at meals as per the plan of care, that the interventions were to be provided as per the plan

of care and that special instruction to support intake were also to be followed.

B) The plan of care for an identified resident indicated a specific bedtime routine.

Observation of care provided by a PCP showed the PCP did not complete care for bedtime routine as per the plan of care.
During an interview with the PCP, they stated that the care plan indicated a specific bedtime routine.The PCP stated that the bedtime routine had not been provided based on the plan of care.

The plan of care for an identified resident , indicated a specific transferring routine.

Observation of care provided by a PCP showed the resident being transferred by the PCP in a manner that was not as specified in the plan of care.

The PCP stated that they had transferred the identified resident in a manner that was not what was indicated in the plan of care.

Coordinator St Mary's stated that is was the expectation that care would be provided as per the plan.

C) A Critical Incident System (CIS) report was submitted by the home in response to a complaint raised by the family, alleging abuse of a resident by staff resulting in injury.

The plan of care for the identified resident identified several focuses of required care with specific interventions for each.

A Personal Care Provider (PCP) stated that care that was provided to the resident should include the interventions as outlined in the plan of care for the resident and was to be provided to the resident by staff of Mount Hope.

During observation by Inspector #537, care was provided to the resident that was not consistent with the focuses and interventions in the plan of care.

Another identified Personal Care Provider (PCP) stated that the staff at the home were to provide all care to the resident as specified in the plan of care. The PCP stated that they had participated in providing care to the identified resident that was not consistent

with the plan of care.

Coordinator St Mary's stated that staff employed by the home were expected to provide the care as specified in the plan of care to the resident.

D) The licensee has failed to ensure that there was a system in place to monitor that the care set out in the plan of care was being provided to residents as specified in the plan including who would be responsible for monitoring.

The action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and revised August 2017 stated the following:
"Care Plans:
A comprehensive audit and revision of existing care plans to ensure they set out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident, based on resident's needs and preferences. Person responsible – coordinators to supervise registered staff; timeframe November 2016 to January 2017; update of July 7, 2017 completed."

Inspector #658 found that the home had not successfully implemented their corrective action plan, noting the following:
- No Saint Mary audits were provided – confirmed by SM Coordinator
- 12 page of audits were provided by Marian Villa Coordinator, and Coordinator MV stated that these were not all of the care plan audits completed.

The licensee has failed to ensure that all audits were completed to monitor that the care set out in the plan of care was being provided to residents as specified in the plan for all residents as outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care". [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the care need of the resident changed.

On May 29, 2017, in inspection #2016_457630_0045 Compliance Order (CO) #011, the licensee was ordered to take action to achieve compliance by ensuring that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed for all residents. The licensee would also ensure that that their action plan outlined in the :Compliance and improvement report for Mount Hope

Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure there was a system in place to monitor that when a resident's care needs changed, the resident was reassessed and the plan of care reviewed and revised, including who was responsible for monitoring. compliance date of June 30, 2017

A) Critical Incident System (CIS) report submitted by the home, identified potential staff to resident abuse.

The plan of care for an identified resident was reviewed, and indicated a specific transferring technique. Observation of the resident room found a logo posted on the wall that indicated a transfer technique which was different from that outlined in the plan of care. Personal Care Provider (PCP) stated that the resident had been transferred by staff using the technique on the logo on the wall and not by the technique outlined in the plan of care.

The plan of care for the resident indicated a specific intervention for the management of incontinence. Observation of care provided to the resident showed all staff using an intervention for incontinence, different from the plan of care. The PCP stated that the intervention in the plan of care had not been what was provided to or required by the resident for the management of incontinence for an extended period of time.

The plan of care for the resident indicated a specific Bedtime Routine and toileting program for the night shift. A PCP stated that the interventions in the care plan were no longer used by the resident.

Coordinator St Marys' stated that the plan of care for the resident had not been reviewed and revised when the care needs of the resident changed.

B) Inspector #630 observed an identified resident in the dining room during a meal service. The resident was observed to require verbal and physical cues from staff throughout the meal and was using a specific device to aid in eating.

Review of the clinical record for the resident showed care plan interventions that included use of specific devices and techniques to be used during meal service, based on assessment of the resident and family requests.

The Registered Dietitian (RD) told Inspector #630 that the resident generally ate poorly

and the family had been quite concerned. When asked how staff would know if a resident required specific interventions to be implemented at meals, the RD said that it was listed on the plan of care and the tray ticket showing that it was an intervention that was to be provided to the resident. The RD provided a list for the specific interventions in the identified home area and the resident was listed as needing a specific device.

Inspector #630 observed the resident in the dining room at another meal service, observed the resident sleeping intermittently, playing with their apron and food items and was not feeding themselves. The resident was observed to be eating and drinking very little during the meal and PCP and RPN staff were observed providing intermittent verbal and physical cues. Part way through the meal a caregiver was observed in the dining room assisting the resident with the meal through verbal and physical cues. The resident was observed to have been served the meal with interventions as outlined in the plan of care.

An RPN told Inspector #630 that the resident was resistive to assistance at times and without assistance had difficulties feeding themselves. The RPN acknowledged that the resident's required care did not match the plan of care for “eating” and “nutritional status”as the resident required more assistance at meals than was stated in the care plan. The RPN said that the resident required staff to have a flexible approach with care to ensure adequate fluid and food intake. The RPN also identified then need for specific devices to assist with eating and acknowledged this was not listed in the plan of care.

The Coordinator MV told Inspector #630 that it was the expectation in the home that the plan of care would reflect the level of assistance required for eating and the specific interventions required.

C) The licensee has failed to ensure that there was a system in place to monitor that when the resident's care needs changed, the resident was reassessed and the plan of care reviewed and revised including who would be responsible for monitoring.

The action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and revised August 2017 stated the following:
"Care Plans:
A comprehensive audit and revision of existing care plans to ensure they set out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident, based on resident’s needs and preferences.

Person responsible – coordinators to supervise registered staff; timeframe November 2016 to January 2017; update of July 7, 2017 completed."

Inspector #658 found that the home had not successfully implemented their corrective action plan, noting the following:
- No Saint Mary audits were provided – confirmed by SM Coordinator
- 12 page of audits were provided by Marian Villa Coordinator and Coordinator MV stated that these were not all of the care plan audits completed.

The licensee has failed to ensure that all audits were completed to monitor that the care set out in the plan of care was being provided to residents as specified in the plan for all residents as outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care".

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2015_326569_0009 as a Voluntary Plan of Correction (VPC), June 9, 2015, in a Complaint Inspection #2105_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR), June 7, 2016, in a Critical Incident Inspection #2016_217137_0014 as a VPC, and December 12, 2016 in a Resident Quality Inspection #2016_457630_0045, as a Director Referral (DR). [s. 6. (10) (b)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 30th day of November, 2017

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) :	NANCY SINCLAIR (537), AMIE GIBBS-WARD (630), NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2017_536537_0035
Log No. / No de registre :	012053-17, 012057-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 16, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CARE, LONDON 268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2
LTC Home / Foyer de SLD :	Mount Hope Centre for Long Term Care 21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ruthanne Foltz

To ST. JOSEPH'S HEALTH CARE, LONDON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0045, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall ensure the resident-staff communication and response system is properly calibrated so that the level of sound is audible to staff. The licensee shall ensure that the resident-staff communication and response system in all home areas in Marian Villa is audible to all staff providing care to residents at all times.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #005, the licensee was ordered to take action to achieve compliance by ensuring that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was

properly calibrated so that the level of sound was audible to staff. This order was to be complied with by June 30, 2017.

Inspector's #658 and #630 toured Marian Villa to observe the resident-staff communication and response system.

On Marian Villa Fifth Floor, it was observed that the call signalling from a resident room was audible when standing near the resident-staff communication and response system at the nursing station and when standing close to the black phone in the hallway. It was observed that the call signal was not audible towards the end of the hallway past the identified room or in the resident rooms.

A Registered Nurse (RN) told the inspectors that staff would know that a resident had activated the resident-staff communication and response system by the light outside the room as well as the intercom at the nursing station and the phones in the hallways. The RN said the home did not use pagers as part of the system. The RN said that the phones in the hallways were now locked in a box mounted on the wall. The inspectors activated the call response system in the presence of the RN and this staff member acknowledged that it was not audible towards the end of the hallway or from within the identified room. The RN said that this was the first time they had become aware that the resident-staff communication and response system was not audible in that area.

On Marian Villa Fourth Floor, it was observed that the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in the hallway outside the room or in the resident rooms.

A Personal Care Provider (PCP) responded to the resident-staff communication and response system for the room and said they had been notified by the light in the hallway. During this interview, the inspectors could not hear the resident-staff communication and response system when standing in the hallway and in the room while the PCP said that they could hear the system.

On Marian Villa Second Floor, it was observed that the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in other rooms on the unit. It was also observed that the resident-staff communication and response system was not audible from within the dining

room.

A PCP, while in the dining room, acknowledged to the inspectors that they could not hear the resident-staff communication and response system in that area. A PCP said that there were other areas where staff could not hear the system such as in resident rooms when providing care and when in the report room.

On Marian Villa First Floor, it was observed the call signalling from an identified room was audible when standing near the resident-staff communication and response system at the nursing station but was not audible in the hallway, even when standing in front of the phone, or in the resident room.

A PCP acknowledged to the inspectors that they could not hear the resident-staff communication and response system in the hallway. A PCP said that usually they would hear the system from the phone in the hallway but that phone was not working at the time of observation. A PCP said that apart from the intercom at the nursing station and the phones in the hallway they did not have another means to hear the system.

Inspector's #658 and #630 toured Marian Villa with Coordinator Marian Villa (MV) . Coordinator MV said that although they were aware of the home's plan regarding the compliance orders related to the resident-staff communication and response system, it was the former Director and the Director of Facilities Management (DOFM) who had been the most involved addressing this issue. Coordinator MV said the staff relied on the auditory part of the system from the intercom at the nursing station and the phones in the hallways. During this tour, Coordinator MV acknowledged that the resident-staff communication and response system was not audible to staff in all areas of the home. During the tour, it was observed that the system was not audible in several areas on multiple floors of Marian Villa.

The Director of Facilities Management (DOFM) told Inspector's #658 and #630 they were familiar with the Compliance Order (CO) related to the resident-staff communication and response system and the home's compliance plan that was created. When asked what changes had been made in the home related to CO #005, DOFM said that previously the issue had been that the phones in the hallways were being turned down by staff and could not be heard from all areas. DOFM said in response to the CO they turned the phones to maximum volume and then closed them into a box. DOFM said there was no way for staff to turn

down the volume on the phones unless they accessed them by a key. When asked what was done after the boxes were put on the phones to check on whether they were audible, DOFM said they had not heard of any problems since the changes were made and the staff never brought forward any concerns.

Inspector's #658 and #630 toured Marian Villa with DOFM . During this tour, DOFM acknowledged that the resident-staff communication and response system was not audible to staff in all areas of the home. During the tour, it was observed that on Marian Villa, the system was not audible in several areas. DOFM also said that the covers over the phones were just an interim solution. At the end of the tour, DOFM said they were going to have a staff member go around and recalibrate all alarms including at the nursing station and also planned to have staff check the resident-staff communication and response system regularly.

The Quality Project Lead said that as part of the response to CO #005, the home had started doing "Management By Walk About" (MBWA) audits. Quality Project Lead said as part of the MBWA audits, the management in the home had been checking on the resident-staff communication and response system. They said that the audits had focused on the audibility of the system at times but the main focus had been on staff response time. Inspector #630 reviewed the MBWA audits forms with Quality Project Lead and they identified that there had been an audit which documented that the "volume was low" on the phone on Marian Villa Fifth Floor. Quality Project Lead said they spoke with staff at the time and they said that they could hear it. Quality Project Lead said the management team completed a "MBWA Weekly Review" where they discussed issues that were identified during the audits. They said that the audibility of resident-staff communication and response system in Marian Villa had not been identified or discussed as a concern at these meetings. Quality Project Lead said that they were planning to have more focus during the audits for this issue.

Inspector #630 toured Marian Villa to observe the resident-staff communication and response system. During this tour, it was observed that on Marian Villa Fourth Floor the system was not audible in the resident lounge and in the hallway and on Marian Villa First Floor, the system was not audible in the hallway During this tour, a PCP acknowledged to Inspector #630 that the resident-staff communication and response system on Marian Villa First Floor could not be heard in the hallway outside of an identified room 112 and said that they heard the home was in the process of addressing this issue.

A resident , who lived in Marian Villa , told Inspector #630 that they had noticed that the resident-staff communication and response system in their room and bathroom did not make a sound when they activated it for assistance. The resident asked Inspector #630 if this was going to be repaired as they had concerns about the system particularly when they were in the bathroom. The resident said that sometimes they had to wait for assistance from staff after activating the system in the bathroom.

DOFM told Inspectors #658 and #630 that it was the expectation that the call response system would have a level of sound that was audible to staff in all areas of the home, including the hallways and dining rooms in Marian Villa.

Based on these observations and interviews, the licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff in Marian Villa.

The severity level was determined to be level two with potential for actual harm. The scope of this issue was wide spread during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 12, 2016 in the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 17. (1) (g)] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0045, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, is implemented. The licensee shall ensure that all staff are educated on the home's policy including reporting mechanisms and that there is a monitoring process in place to ensure that the home's abuse policy is implemented.

The education and training provided to all staff must include re-education regarding sexual abuse. This education must address consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #002, the licensee was ordered to take action to achieve compliance by ensuring that the home's written policy to promote zero tolerance of abuse and

neglect was complied with. This CO also stated that the licensee was to also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure that all staff were educated on the home's policy including reporting mechanisms and that there was a monitoring process in place to ensure that the home's abuse policy was implemented. The education and training provided to all staff was to include re-education regarding sexual abuse. This education was to address consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities. This order was to be complied with by August 31, 2017.

The home's policy "Abuse and Neglect of Residents: Zero Tolerance" with "Revised Date September 27, 2016" and "Reviewed Date November 8, 2016" included the following procedures:
- 1.2.2. "Staff education and training will include:
a) policy and procedures for zero tolerance of abuse and/or neglect including definitions of abuse and neglect and use of Ministry of Health and Long Term Care (MOHLTC) Licensee Reporting of Abuse Decision Tree;
b) policy and procedures on reporting of inappropriate activities (i.e. whistle blowing) and protection from retaliation"

Section 2(1) of the Long Term Care Homes Act 2007 defined "staff" in relation to a long-term care home as "persons who work at the home as employees of the licensee, pursuant to a contract or agreement with the licensee or pursuant to a contract or agreement between the licensee and an employment agency or other third party."

A caregiver was observed working with a resident. During an interview, the caregiver stated that they worked in the home through an agency as a companion to a resident every day, and that they had been doing this for about a year.

During an interview, the caregiver told an inspector that they did receive orientation from the agency they were employed by prior to starting but said this did not include education on Mount Hope's written policy on the prevention of abuse or neglect or the process for reporting abuse. When asked if the home had provided any training regarding prevention of abuse, including sexual

abuse, the caregiver said they had not participated in this type of education.

Human Resources (HR) Manager for the agency told Inspector #630 that they had Personal Support Workers (PSWs) who worked at Mount Hope as one to one companions as well as in any Personal Care Provider (PCP) shifts. When asked about training that was provided to the staff, HR Manager said that when they were hired they received orientation from the agency and education on their internal policies. When asked if their staff received training on the Mount Hope policy on prevention of abuse and neglect they said the agency staff had not been trained on this policy. When asked if the agency staff participated in classroom training or orientation when they started working at Mount Hope from the home, HR Manager said they did not participate in that education. When asked if any of the agency staff received training on abuse from Mount Hope, they said that the staff did not receive this education. When asked how many staff they had working at Mount Hope, they said they did not know but would find out.

Coordinator MV told Inspector #630 that the caregiver worked for an agency and did not receive training from Mount Hope regarding the home's written policy and procedures on prevention of abuse and neglect. When asked about the education provided to staff working through agencies in general, Coordinator MV said that she was not sure if the companies have received education packages but could find out from Staff Educator. When asked about the orientation these staff received when they started working at Mount Hope, Coordinator MV said they had a booklet on the unit that outlined their duties and information on the resident but they did not participate in classroom training as the education was provided to them through the agency. During the interview Coordinator MV called Staff Educator and was told that the staff from the agency did not receive training within the home including the training that was done in the summer on prevention of abuse and neglect and sexual abuse or the responsive behaviours program.

The Staff Educator told Inspector #630 that the education provided to PSWs working in the home through agencies differed depending on the agency. Staff Educator said that staff working through one agency employed by the home had to complete education provided through their agency which included an orientation package provided by Mount Hope prior to working in the home. Staff Educator said this education included information about the home's written policy on the prevention of abuse and neglect. When asked if this education

addressed consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including consent, Staff Educator acknowledged that it did not. Staff Educator said that none of the PSWs working through agencies participated in the education provided to staff on sexual abuse. Staff Educator said that the PSWs working for two other outside agencies did not receive education on Mount Hope's written policy on prevention of abuse and neglect or the recent education on sexual abuse.

Scheduling Leader said that PSWs from the three outside agencies employed by the home were scheduled for shifts at Mount Hope either as caregivers or in PCP shifts. Scheduling Leader identified a total of 96 shifts worked by agency staff in a specific18 day time frame.

A caregiver said that they had been working at Mount Hope through an agency for about two and a half years. The caregiver said that they thought they had received education on prevention of abuse and neglect about two and half years ago but did not recall education about the Mount Hope policy on prevention of abuse and neglect. The caregiver said that they had not recently received education regarding prevention of abuse or sexual abuse when it was presented to Mount Hope staff.

HR Manager of a specific agency told Inspector #630 that they had 54 PSW staff who had been working at Mount Hope.

Coordinator MV said it was the expectation in the home that all staff would comply with the home's written policy on the prevention of abuse and neglect which included procedures on staff education and reporting of alleged abuse or neglect.

Coordinator MV said it was the expectation in the home that all staff, including staff working through agencies, received education on the home's policy on the prevention of abuse and neglect and as per CO #002 re-education regarding sexual abuse which addressed consensual versus non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by anyone including who can and cannot consent to these sexual activities. Coordinator MV acknowledged that this education was not provided to all staff of the home.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the

course of this inspection. There was a compliance history of this legislation being issued in the home on December 7, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_260521_0057, on January 7, 2016, in a Complaint Inspection #2016_260521_0002 as a VPC, on May 26, 2016, in Critical Incident Inspection #2016_226192_0022 as a Compliance Order (CO) and a Director's Referral (DR), on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a VPC and on December 12, 2016 during the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 20. (1)] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0045, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will protect all residents from abuse by anyone and shall ensure that residents are not neglected by the licensee and staff.

The licensee will implement their action plan, in part, outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016. Education and training shall be provided to all staff including the home's policy to promote zero tolerance of abuse. The licensee will monitor, evaluate and adapt their compliance plan to ensure all residents will be protected from abuse and neglect.

In addition to the previously required re-education regarding sexual abuse, the re-education will also include verbal and emotional abuse of all residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Section 2(1) of Ontario Regulation 79/10 defined emotional abuse as 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.

Section 2(1) of Ontario Regulation 79/10 defined verbal abuse as any form of

verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order #001, the licensee was ordered to take action to achieve compliance by ensuring that all residents were protected from abuse by anyone and that residents are not neglected by the licensee or staff. This CO also stated that the licensee was also to ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure that all staff were to be provided education and training that included the home's policy to promote zero tolerance of abuse. The licensee would monitor, evaluate and adapt their compliance plan to ensure all residents would be protected from abuse and neglect. This order was to be complied by August 31, 2017.

A Critical Incident System (CIS) report submitted by the home identified potential staff to resident abuse, as reported by the family of a resident. The report stated that the family had concerns with regards to care they had observed, involving several staff. The family submitted a MOHLTC Infoline regarding the same concerns and allegations.

Interview with the family was conducted who shared what they had observed and their concerns.

The care plan for the identified resident indicated specific interventions in place to ensure care was provided in a manner consistent with identified medical concerns, personal preferences, and assessed care needs.

a) Inspector #537 reviewed the care provided during three specified time periods which identified potential abuse to a resident by staff members.

During an interview with an identified staff member, they stated that they were aware of the allegations that had been raised and stated that they did not feel the accusations were accurate. The staff member did state that they had provided care that was not consistent with the needs and preference of the resident, and that their conversation with the resident was not intended to be

degrading or to minimize the feelings of the resident. The staff member stated that the actions were completed to ensure the care was completed before the end of shift.

During an interview with another identified staff member, they acknowledged that they had not provided care safely as per the assessed needs of the resident and as per their personal needs and preferences.

During an interview with an additional identified staff member, they acknowledged that they were aware that there had been allegations raised regarding their conduct in providing care to the identified resident, but denied that they had any recollection of any of the incidents that were alleged.

Coordinator St Mary's (SM) stated that they were aware of the observations made and the concerns of the family and that the actions, and verbalizations of the staff was inappropriate and not what was expected of staff to residents, and implemented their own internal processes to address the staff member involved.

The licensee has failed to protect a resident from abuse.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of this legislation being issued in the home on May 26, 2016, in Critical incident Inspection #2016_226192_0022 as a Director's Referral (DR), on June 7, 2016, in Critical Incident Inspection #2016_217137_0014 as a Compliance Order (CO), and on December 12, 2016in the Resident Quality Inspection #2016_457630_0045 as a Director Referral (DR). [s. 19. (1)] (537)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0045, CO #010;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee will ensure that the care set out in the plan of care is provided to the resident as specified in the plan, for all residents and specifically:

a) That the care set out in the plan of care for the identified residents is provided to the residents as specified in the plan.

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and then further updated on August 9, 2017, is implemented.

The licensee shall ensure there is a system in place to monitor that the care set out in the plan of care is being provided to residents as specified in the plan including who will be responsible for monitoring.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On May 29, 2017, inspection number 2016_457630_0045 Compliance Order (CO) #010, the licensee was ordered to take action to achieve compliance by ensuring the care set out in the plan of care was provided to the resident as specified in the plan, for all residents. The licensee was also to ensure that there was a system in place to monitor that the care set out in the plan of care was being provided to residents as specified in the plan including who would be

responsible for monitoring. This order was to be complied with by June 30, 2017.

A) An inspector observed a resident in the dining room during a meal. The resident had multiple food items in front of them. The resident was observed to be eating and drinking very little during the meal. Not all items as identified in the plan of care for this resident for eating were observed to be in use.

Review of the clinical record for the resident showed care plan interventions that included use of specific devices and techniques to be used during meal service, based on assessment of the resident and family requests.

The Registered Dietitian (RD) told Inspector #630 that the resident generally ate poorly and the family had been quite concerned.The RD said that if the plan of care identified that specific interventions were required to support food and fluid intake then it would be up to the nursing staff to ensure that this was done at meals, and that all identified interventions should be used.

Inspector #630 observed the identified resident in the dining room during another meal service. The resident again had multiple items in front of them, contrary to the plan of care, as well as specific devices not being used. The resident was again observed to be eating and drinking very little during the meal. Part way through the meal a caregiver was observed in the dining room assisting the resident with the meal through verbal and physical cues. Inspector #630 then spoke with an RPN regarding the plan of care for "eating" and "nutritional status" compared to the care being provided to the resident during the meal service. The RPN acknowledged that the care being provided to the resident did not match the plan of care.

The caregiver told Inspector #630 that they were assigned to the resident for the day shift and this was their first time working with this resident. When asked how they found out about the resident's care needs they said they looked at the "caregiver plan of care: expectations and interventions" booklet in the resident's room. Inspector #630 reviewed the plan of care in this booklet with the caregiver and it was identified that this plan of care stated that the caregivers were not to be providing any personal care for the resident including assistance at meals. The caregiver acknowledged that they had been assisting the resident in the dining room with their meal and that they were not aware of the contents of the plan of care in Point Click Care (PCC) related to eating assistance or nutritional

status as they did not review these prior to the shift.

Coordinator MV told Inspector #630 that it was the expectation in the home that staff would provide care to the resident as per the plan of care. Reviewed the plan of care in PCC and the "caregiver plan of care: expectations and interventions" and Coordinator MV said that it was the expectation caregivers were not to be providing assistance at meals as per the plan of care, that the interventions were to be provided as per the plan of care and that special instruction to support intake were also to be followed.

B) The plan of care for an identified resident indicated a specific bedtime routine.

Observation of care provided by a PCP showed the PCP did not complete care for bedtime routine as per the plan of care.
During an interview with the PCP, they stated that the care plan indicated a specific bedtime routine.The PCP stated that the bedtime routine had not been provided based on the plan of care.

The plan of care for an identified resident , indicated a specific transferring routine.

Observation of care provided by a PCP showed the resident being transferred by the PCP in a manner that was not as specified in the plan of care.

The PCP stated that they had transferred the identified resident in a manner that was not what was indicated in the plan of care.

Coordinator St Mary's stated that is was the expectation that care would be provided as per the plan.

C) A Critical Incident System (CIS) report was submitted by the home in response to a complaint raised by the family, alleging abuse of a resident by staff resulting in injury.

The plan of care for the identified resident identified several focuses of required care with specific interventions for each.

A Personal Care Provider (PCP) stated that care that was provided to the

resident should include the interventions as outlined in the plan of care for the resident and was to be provided to the resident by staff of Mount Hope.

During observation by Inspector #537, care was provided to the resident that was not consistent with the focuses and interventions in the plan of care.

Another identified Personal Care Provider (PCP) stated that the staff at the home were to provide all care to the resident as specified in the plan of care. The PCP stated that they had participated in providing care to the identified resident that was not consistent with the plan of care.

Coordinator St Mary's stated that staff employed by the home were expected to provide the care as specified in the plan of care to the resident.

D) The licensee has failed to ensure that there was a system in place to monitor that the care set out in the plan of care was being provided to residents as specified in the plan including who would be responsible for monitoring.

The action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and revised August 2017 stated the following:
"Care Plans:
A comprehensive audit and revision of existing care plans to ensure they set out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident, based on resident's needs and preferences. Person responsible – coordinators to supervise registered staff; timeframe November 2016 to January 2017; update of July 7, 2017 completed."

Inspector #658 found that the home had not successfully implemented their corrective action plan, noting the following:
- No Saint Mary audits were provided – confirmed by SM Coordinator
- 12 page of audits were provided by Marian Villa Coordinator, and Coordinator MV stated that these were not all of the care plan audits completed.

The licensee has failed to ensure that all audits were completed to monitor that the care set out in the plan of care was being provided to residents as specified in the plan for all residents as outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care". [s. 6. (7)] (537)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0045, CO #011;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee will ensure the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change, for all resident's, and specifically:

a) That the identified residents are reassessed and the plan of care is reviewed and revised at any time when the residents' care needs change

The licensee will also ensure that their action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and further revised on August 9, 2017, is implemented.

The licensee shall ensure there is a system in place to to monitor that when a resident's care needs change, the resident is reassessed and the plan of care reviewed and revised, including who will be responsible for monitoring.

Grounds / Motifs :

1. 2. The licensee has failed to ensure that the plan of care was reviewed and revised when the care need of the resident changed.

On May 29, 2017, in inspection #2016_457630_0045 Compliance Order (CO) #011, the licensee was ordered to take action to achieve compliance by ensuring that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed for all residents. The licensee would also ensure that that their action plan outlined in the :Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, was implemented. The licensee was to ensure there was a system in place to monitor that when a resident's care needs changed, the resident was reassessed and the plan of care reviewed and revised, including who was responsible for monitoring. compliance date of June 30, 2017

A) Critical Incident System (CIS) report submitted by the home, identified potential staff to resident abuse.

The plan of care for an identified resident was reviewed, and indicated a specific transferring technique. Observation of the resident room found a logo posted on the wall that indicated a transfer technique which was different from that outlined in the plan of care. Personal Care Provider (PCP) stated that the resident had been transferred by staff using the technique on the logo on the wall and not by the technique outlined in the plan of care.

The plan of care for the resident indicated a specific intervention for the management of incontinence. Observation of care provided to the resident showed all staff using an intervention for incontinence, different from the plan of care. The PCP stated that the intervention in the plan of care had not been what was provided to or required by the resident for the management of incontinence for an extended period of time.

The plan of care for the resident indicated a specific Bedtime Routine and toileting program for the night shift. A PCP stated that the interventions in the care plan were no longer used by the resident.

Coordinator St Marys' stated that the plan of care for the resident had not been reviewed and revised when the care needs of the resident changed.

B) Inspector #630 observed an identified resident in the dining room during a meal service. The resident was observed to require verbal and physical cues

from staff throughout the meal and was using a specific device to aid in eating.

Review of the clinical record for the resident showed care plan interventions that included use of specific devices and techniques to be used during meal service, based on assessment of the resident and family requests.

The Registered Dietitian (RD) told Inspector #630 that the resident generally ate poorly and the family had been quite concerned. When asked how staff would know if a resident required specific interventions to be implemented at meals, the RD said that it was listed on the plan of care and the tray ticket showing that it was an intervention that was to be provided to the resident. The RD provided a list for the specific interventions in the identified home area and the resident was listed as needing a specific device.

Inspector #630 observed the resident in the dining room at another meal service, observed the resident sleeping intermittently, playing with their apron and food items and was not feeding themselves. The resident was observed to be eating and drinking very little during the meal and PCP and RPN staff were observed providing intermittent verbal and physical cues. Part way through the meal a caregiver was observed in the dining room assisting the resident with the meal through verbal and physical cues. The resident was observed to have been served the meal with interventions as outlined in the plan of care.

An RPN told Inspector #630 that the resident was resistive to assistance at times and without assistance had difficulties feeding themselves. The RPN acknowledged that the resident's required care did not match the plan of care for "eating" and "nutritional status"as the resident required more assistance at meals than was stated in the care plan. The RPN said that the resident required staff to have a flexible approach with care to ensure adequate fluid and food intake. The RPN also identified then need for specific devices to assist with eating and acknowledged this was not listed in the plan of care.

The Coordinator MV told Inspector #630 that it was the expectation in the home that the plan of care would reflect the level of assistance required for eating and the specific interventions required.

C) The licensee has failed to ensure that there was a system in place to monitor that when the resident's care needs changed, the resident was reassessed and the plan of care reviewed and revised including who would be responsible for

monitoring.

The action plan outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care" which was previously submitted to the Director on November 28, 2016, and revised August 2017 stated the following: "Care Plans:
A comprehensive audit and revision of existing care plans to ensure they set out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident, based on resident's needs and preferences. Person responsible – coordinators to supervise registered staff; timeframe November 2016 to January 2017; update of July 7, 2017 completed."

Inspector #658 found that the home had not successfully implemented their corrective action plan, noting the following:
- No Saint Mary audits were provided – confirmed by SM Coordinator
- 12 page of audits were provided by Marian Villa Coordinator and Coordinator MV stated that these were not all of the care plan audits completed.

The licensee has failed to ensure that all audits were completed to monitor that the care set out in the plan of care was being provided to residents as specified in the plan for all residents as outlined in the "Compliance and improvement report for Mount Hope Centre for Long Term Care".

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of this legislation being issued in the home on August 13, 2014, in a Complaint Inspection #2015_326569_0009 as a Voluntary Plan of Correction (VPC), June 9, 2015, in a Complaint Inspection #2105_183135_0024 as a VPC, January 5, 2016, in a Resident Quality Inspection #2016_254610_0001 as a VPC, in a Critical Incident Inspection #2016_226192_0022 as a Director's Referral (DR), June 7, 2016, in a Critical Incident Inspection #2016_217137_0014 as a VPC, and December 12, 2016 in a Resident Quality Inspection #2016_457630_0045, as a Director Referral (DR). [s. 6. (10) (b)] (537)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 16th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Nancy Sinclair

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