Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 14, 2019	2019_618211_0001 (A1)	008098-18, 008850-18, 010656-18, 011657-18, 020194-18, 020710-18, 022002-18, 022116-18, 022120-18, 023291-18, 026503-18, 027110-18, 027482-18, 028225-18, 028994-18, 029414-18, 031713-18, 032020-18, 032353-18, 033203-18, 033450-18	Critical Incident System

Licensee/Titulaire de permis

The Perley and Rideau Veterans' Health Centre
1750 Russell Road OTTAWA ON K1G 5Z6

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

The Perley and Rideau Veterans' Health Centre
1750 Russell Road OTTAWA ON K1G 5Z6

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

Amended by JOELLE TAILLEFER (211) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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The changes to these inspection reports were requested by the licensee and are as follows; the reference to the number of documented incidents of physical aggression and physical abuse involving resident #001 were corrected.

Issued on this 14th day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by JOELLE TAILLEFER (211) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2019

The following Critical Incident System intake(s) related to Prevention of Abuse were completed during this inspection: Logs #008098-18, #011657-18, #022002-18, #022116-18, #022120-18, #023291-18, #026503-18, #020710-18, #027482-18, #031713-18, #032020-18, #032353-18.

The following Critical Incident System intake(s) related to Responsive Behaviours were completed during this inspection: Logs # 008850-18, #010656-18, #026503-18, #027110-18.

The following Critical Incident System intake(s) related to Skin and Wound Care was completed during this inspection: Log # 020194-18.

The following Critical Incident System intake(s) related to Falls Prevention were completed during this inspection: Logs #028225-18, #028994-18, #033450-18, #033203-18.

The following Critical Incident System intake(s) related to 24-hour Admission was completed during this inspection: Log #029414-18.

During the course of the inspection, the inspector(s) spoke with Chief Operating Officer, Director of Nursing (DOC), Director Clinical Practice, Managers of Resident Care (MRC), Personal Support Worker Supervisors, Sub-Acute Admission, Employee Health Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Special Approach Personal Support Worker (BSO) and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that residents of the home are protected from physical abuse by resident #001.

This finding is related to Intake Log #026503-18.

Under O.Reg. 79/10, 2. (1) For the purposes of the definition of "abuse" in

subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2),

(c) the use of physical force by a resident that causes physical injury to another resident".

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date reporting the witnessed physical abuse of resident #004 by resident #001. It was reported in the CIS that resident #001 was holding on resident #004 and was hitting them. Resident #004 sustained an injuiry.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), one month later, reporting the witnessed physical abuse of resident #003 by resident #001. It was reported in the CIS that resident #001 struck out when approached by resident #003. Resident #003 sustained two small injuries.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), the next month, reporting the alleged physical abuse of resident #002 by resident #001. It was reported in the CIS that resident #002 was in an identified area with resident #001, resident #002 screamed and ran out from the area. Resident #002 was assessed and noted an injury to a specific area of the body.

Inspector #593 reviewed resident #001's progress notes and found 32 documented incidents of physical aggression with contact by resident #001 and 3 incidents of physical abuse towards co-residents in the home, including the three CIS reports detailed above. Following are the incidents that occurred over the past six months, prior to this there were other multiples documented incidents within two months.

On an identified date during the morning hours- resident #001 grabbed resident #029 when they approached them in an identified area.

The previous month during the evening hours- resident #001 punched resident #029. PSW #157 reported being in another resident's room trying to redirect resident when co-resident entered. PSW #157 was unable to intervene in time when resident #001 punched co-resident.

On the same day during the afternoon hours- the high intensity monitoring PSW #158 reports that resident #001 was approached by resident #030 in a specific area at lunchtime. Resident #001 grabbed onto co-resident's identified body area.

On another previous month during the morning hours- Resident #030 was walking in the hallway in front of an identified room, touched resident #001 and poured some identified liquid on them. Resident #001 was upset and grabbed resident #030 and held them very tight. RPN #156 turned around, saw the action, and separated both residents.

The other previous month during the evening hours- Resident #001 was seated in a specific area when resident #031 approached to sit down at seat near resident #001. Resident #031 placed their right hand on table when sitting down. Resident #001 became agitated and grabbed resident #031's arm and squeezed. Resident #031 began vocalizing loudly and became visibly agitated. PSW #155 providing high intensity monitoring was asked what happened and they replied "I don't know".

Nine days prior the above incident during the evening hours- PSW reported that resident #002 screamed and ran out of resident #001's room. Resident #002 was assessed and noted an injury to a specific body area (submitted as a CIS).

Six days prior the above incident during the evening hours- Resident #001 was sitting in a specific area when resident #030 walked by and approached resident #001. Resident #001 grabbed resident #030. RPN #113 reported that it appeared resident #001 was trying to injure the other resident.

On another identified month during the evening hours- Resident #001 was seated on a chair at an identified area, resident #003 approached carrying an item and placed the item on resident #001's lap. Resident #001 struck out at resident #003 and spoke to resident #003 in a angry voice while attempting to strike out at resident. Resident #003 had an injury and the area was treated (submitted as a CIS).

Three days prior the above incident during the day hours- Resident #001 was in an identified area eating, resident #032 approached them and reached for the food. Resident #001 grabbed resident #032 and hit them in an identified area of the resident's body.

On the same day, five minutes prior the other indicent- Resident #001 grabbed resident #033 as they were ambulating past the resident's specific area. Resident #033 attempted to pull away, however resident #001's grip was too strong and the PSW had to intervene.

Twelve days prior the above incident during the evening hours- Resident #031 had a fall and was calling out, resident #001 got out of their chair and walked over to resident #031 and hit the resident on a particular body area while talking to them.

One month prior the above incident during the evening hours- Resident #001 grabbed resident #130. Unwitnessed by staff who were in the dining room at that time. Staff were able to separate residents from each other.

One day prior the above incident during the evening hours- RPN #159 heard a noise from resident's room. PSW #115 was in another resident's room when they went in to check trying to separate resident #001 and resident #002. Resident #001 had grabbed resident #002 with an angry look on their face.

On the same day, Resident #002 walked by resident #001 and stated "that's mine" and pointed to an item. Resident #001 grabbed resident #002 and pulled the resident towards them self as they walked by. It was reported that it was difficult to redirect resident #001 away from resident #002 with a second staff member required.

Three days prior the above incident during the evening hours- At approximately one hour prior the incident, resident #001 was in a specific area. Resident #034 was being escorted to the the specific area and crying loudly. Resident #001 asked the PSW to "quieten down your buddy". Resident #001 moved toward resident #034 and grabbed the back of the resident's clothes.

Eight days prior the above incident during the evening hours- Earlier during the evening shift, resident #030 approached resident #001 and reached to touch them. Resident #001 grabbed resident #030 and twisted body area slightly.

Two days prior the above incident during the evening hours- Resident #001 was physically aggressive towards resident #002. Resident #001 was holding resident #002's specific body area and tried to squeeze it. Resident #001 stated that resident #002 came into a specific area and they see what happens".

On day prior the above incident during the late evening hours- Three hours earlier, resident #030 approached resident #001 and entered their personal space. Resident #030 reached out to grab resident #001. Resident #001 grabbed resident #030 and yelled. Resident #001 observed to have an angry facial expression. Staff attempted to remove resident #001's hands from resident #030's specific body area but they had a firm grip and initially refused to let go. Staff were then able to get resident #001 to let go and they were redirected to their room.

Two days prior the above incident during the early afternoon- Resident #001 was sitting in a specific area with both of their hands grabbing the clothes of resident #004. Resident #001 hit them in a specific body area. There was a small amount of an injury on resident #004 on two specific body areas (submitted as a CIS).

Five days prior the above incident during the evening shift- At a identified hours, a PSW reported that resident #001 grabbed resident #030 and when the PSW intervened, resident #001 punched resident #030 on an identified body area. As per the PSW, resident #030 was trying to lean towards resident #001 and touched in a specific way.

On the same above day during the morning shift- After meal, resident #001 went back to their room, they quickly started grabbing and punching resident #035. Resident #035 had entered resident #001s personal space, who responded by punching resident #035.

Three days prior the above incident during the evening hours- Resident #001 was seated when another resident approached them and touched resident #001's identified body area. Resident #001 grabbed co-resident.

Two days prior the above incident during the evening shift- Resident #030 approached resident #001 in a specific area. Resident #001 grabbed resident #030, resident #001 had a mad facial expression.

Resident #001 was admitted to the home in an identified date.

A review of resident #001's current care plan on an identified date, documented the following focus and interventions:

Focus: High intensity needs during high risk times for specified times on a daily

basis.

Interventions:
• Continuous high intensity needs monitoring for identified times on a daily basis. Registered Staff are to assess the need of high intensity monitoring at other times when resident is awake.
Resident does not like to be approached by co-residents; redirect co-residents from approaching resident. Staff to stand between co-residents and resident.

Focus: Verbal/physical responsive behaviour as evidenced by (hitting, pushing staff and co-residents) related to: Cognitive impairment.

Interventions:
• High intensity monitoring support as preventative measure to help minimize interactions with co-residents.
• Monitor, document and report responsive behaviour.
• Closely monitor resident and redirect the resident away from co-resident's in identified rooms due to previous physically aggressive incidents with.

A review of resident #001's progress notes indicated that increased monitoring, through high intensity monitoring of resident #001 was initiated four months after the admission. Progress notes indicate that the high intensity monitoring was put into place for seven identified hours per day. One month later, the high intensity monitoring hours were increased to thirteen hours daily.

A review of resident #001's physician's orders found the following documented orders:

• On an identified date- High intensity monitoring for eleven identified hours. To be reassessed after behaviour therapy assessment report and recommendations are available.
• Seven day later- Continue high intensity needs extra staff to minimise risk of harm to others.
• Fourteen weeks and three days later- Continue high intensity needs for thirteen identified hours daily.
• Seven days later- Continue high intensity needs for thirteen identified hours.
• Seven days later- Continue the high intensity for the same above hours.
A review of resident #001's health care record found a high intensity monitoring guidance document, a summary of the document follows:

• Resident #001 is on high intensity monitoring because they are irritated by co-residents and will grab or hit them.
• Triggers:
o Co-residents entering residents #001's personal space
o Co-residents touching resident #001 or their personal device.
o Co-residents vocalising near resident #001
• PSW is to keep co-residents away from resident #001 (especially the nine identified residents).
• Resident #001 can very quickly and unpredictably grab a co-resident that walks by them.
• High risk are in two identified areas. Encourage resident #001 to move out of these areas.
• High risk times are for the nine identified hours.
• If resident #001 is in their room, PSW can be in hall but must closely monitor the door to ensure co-residents do not enter.

During the inspection, Inspector #593 observed the following:

On an identified date,

During a morning time- Resident #001 was observed in the identified area after a specific post meal. Resident #002 was seated in an armchair across from resident #001. The high intensity monitoring staff was not present.

Six minutes later- Resident #001 remains seated in the identified area. Resident #002 was seated in an armchair across from resident #001. The high intensity monitoring staff was not present.

Five minutes later- PSW #115 arrives and interacts with resident #001. PSW #115 confirms that they were resident #001's high intensity monitoring until an identified change of shift.
Six minutes later- PSW #115 cleared resident #001's dishes to an identified area, then washed their hands before returning to resident #001.

Two minutes later- PSW #115 wiped down resident #001's table, returned to the identified area, washed their hands before returning to resident #001. Resident #002 remained seated across from resident #001.

Two minutes later- PSW #115 leaves resident #001 to assist resident #029,

entered the charting room/nurses station and then returned to resident #001.

Four minutes later- PSW #115 removed resident #001's appliance, takes the appliance to the identified area, washed their hands and then returned to resident #001.

Five minutes later- Resident #029 was hovering around resident #001, PSW #115 redirected the resident, then left for another identified area to wash their hands. While PSW #115 was in the identified area, resident #029 returned to the side of resident #001.

Seven minutes later- Resident #002 was observed to approach resident #001, PSW #115 was observed to redirect the resident away from resident #001. PSW #115 indicated that resident #002 liked to touch other resident's identified body area, including resident #001.

The next day

During the early afternoon- Resident #001 was observed in the identified room area during an identified meal service. PSW #114 was observed to take resident #001 back to their room and then return to the identified room. A family member was observed to be visiting with resident #001.

Five minutes later for approximately four minutes- PSW #114 returned to the units corridor, however was observed in resident #036's doorway. PSW #160 had asked PSW #114 to stand by resident #036's door as resident #036 keeps leaving their room. PSW #114 was observed to follow this request. PSW #160 leaves to return to the identified room area. There was no high intensity monitoring with resident #001 during this time.

At approximately two hours later- Inspector #593 was interviewing PSW #114, during that time when PSW #114 realised that their shift had finished, they quickly left the unit and resident #001 was left with no high intensity monitoring. On the identified shift staff were observed at the end of the corridor doing handover, the staff were discussing which PSW was going to monitor resident #001. Three residents were observed actively wandering by resident #001's room at specific time.

- On an identified shift handover ends and PSW #161 joined resident #001 for the

high monitoring.

- On another shift, Inspector #593 entered the corridor of the unit and PSW #161 was not with resident #001. Resident #001 was observed to be in their room with the door closed. PSW #161 was observed at the other end of the corridor. Three residents were observed actively wandering by resident #001's room at this time. PSW #161 sees Inspector #593 standing by resident #001's doorway and returns to this area, telling the Inspector "I have been checking on resident #001 every 10 minutes".

During an interview with Inspector #593, on an identified date, PSW #116 indicated that the role of the high intensity monitoring PSW was to ensure that they have no confrontations with other residents as resident #001 was very unpredictable, "we try to keep the resident busy". Resident #001 does not like other residents in their room, they wander and we have to keep the other residents safe. Resident #001's demeanor changes when another resident approaches, when resident #001 is in an open area and a resident walks by, resident #001 reacts quickly, we have been told not to turn our backs for even two seconds as some of the residents are pretty quick.

During an interview with Inspector #593, on an identified date, PSW #115 indicated that resident #001 requires high intensity monitoring as they are responsive to other residents who are vocalising or in their personal space. Other residents needed to be redirected from resident #001 as they will strike out at other residents. PSW #115 added that resident #001's behaviours do not escalate, it's like hitting a switch, and the resident goes from being nice to striking out trying to punch or kick at staff and residents. PSW #115 indicated that the high intensity monitoring begins at a specific time during the morning and that the timing is strict. PSW #115 said that there have been incidents with both resident #002 and #029 as both of these residents wander into residents #001's personal space and resident #029 is very vocal which is a trigger for resident #001.

During an interview with Inspector #593, on an identified date, PSW #114 indicated that the role of the high intensity monitoring's PSW was to prevent resident #001 having interactions with other residents, keep resident #001 occupied and busy with activities and to redirect other residents away from resident #001. Resident #001's triggers included residents who are too verbal and residents that approach resident #001, we can see resident #001 becoming agitated and they will strike out or grab a co- resident and pull them in. PSW #114

indicated that when resident #001 has a visitor, the high intensity monitoring remains but they will stand by the residents door to their room and make sure no other residents try to enter their room.

During an interview with inspector #593, on an identified date, PSW #112 indicated that resident #001 has a high intensity for monitoring as they get agitated, they will grab and pull onto another resident, the high intensity monitoring PSW is there to intervene. There are more behaviours from resident #001 in the afternoon for 2 hours, as the other residents on the unit are more active and vocal. PSW #112 added that resident #001 was more verbally responsive towards specific residents, and they are more likely to lash out at these residents than other resident and if they are really agitated, they will reach out for residents wandering past. When the resident is in bed, the role of the high intensity monitoring PSW is to prevent other residents from entering their room.

During an interview with Inspector #593, on an identified date, RPN #113 indicated that resident #001 was aggressive towards other residents, if another resident reaches out for them or anytime someone walks by slowly or if they are talking near him, resident #001 will grab them. RPN #113 added that resident #001's behaviour changes very quickly, and other residents are a trigger. The role of the high intensity PSW is to ensure that co-residents can pass safely in the corridor, if other residents are making noise, which they often are, resident #001 will head toward the noise because they are upset, the high intensity monitoring PSW is supposed to redirect them.

During an interview with Inspector #593, on an identified date, RN #111 indicated that resident #001 was triggered by co-residents coming near them, if they are vocalising or they don't make sense, this really irritates them. Resident #001 will reach out and grab them. RN #111 added that resident #001 needs high intensity supervision because the psychiatrist said that there was no medication that can address this behavior, nothing can stop them from being irritated by their co-residents and in this environment, there are many residents wandering and talking, speech is disorganised. The high intensity monitoring is to keep other residents safe, they are to redirect other residents away if they approach or try to enter resident #001's room. RN #111 further indicated that the high intensity PSW should not be leaving resident #001 alone as there were a few instances when resident #001 was sitting away from the other residents in the dining room, the high intensity staff brought their dishes to the kitchen and during this time, resident #029 walked up and resident #001 grabbed them, it happened so quickly.

RN #111 added that resident #001 will get territorial about a spot, they won't move if they are irritable, that's why the identified area room is not good for resident #001, as it is such a high traffic area.

During an interview with Inspector #593, on an identified date, Manager of Resident Care (MRC) #151 indicated that the high intensity monitoring started near the beginning of an identified month for eight hours and was increased to thirteen hours for the next month. MRC #151 said that the high intensity staff is usually a PSW, if it is not a PSW, then it is an RPN and their role is to monitor the resident in their room, they are making sure no other residents are going into their room. If resident #001 is out of their room, the high intensity staff is redirecting other residents away from resident #001 as resident #001 is reactive of other residents in their personal space. The high intensity staff is resident #001's shadow. In response to the incidents that occurred when the high intnsity monitoring was in place, MRC #151 indicated that they did re-education with the staff, we told them you cannot take your eyes off resident #001 for a second. MRC #151 added that resident #001 can be calm and pleasant and then a resident walks past and resident #001 changes very quickly. MRC #151 said that they also have a one page document for staff to refer to which are the responsibilities of the high intensity staff (as described above). MRC #151 confirmed that when a family member was visiting resident #001, the high intensity monitoring was still in effect.

Resident #001 has had 32 documented incidents of physical aggression with contact and 3 incidents of physical abuse towards other residents on the identified unit. Three of these incidents resulted in injury to co-residents. In a specified month, a high intensity monitoring was implemented during the afternoon for eight hours for resident #001 to protect the other residents on the unit, after further incidents, these hours were extended to thirteen hours. Despite, the high intensity monitoring, five additional incidents occurred where resident #001 was able to make physical contact, and inflict force on other residents. During the inspection, Inspector #593 observed on multiple occasions, resident #001 without their high intensity monitoring staff between an identified times for thirteen hours. Resident #001's plan of care documented that they are required to have high intensity monitoring for other residents safety during this time. During these observations, residents involved in previous incidents were allowed to enter resident #001's personal space as the assigned high intensity monitoring was not monitoring the resident. As such, the licensee has failed to ensure that residents of the home are protected from physical abuse by resident #001. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is

provided to the resident as specified in the plan.

This finding is related to Intake Log #020194-18

A critical incident report was submitted to the Director in regards to improper/incompetent treatment of a resident that resulted in harm or risk of harm to resident #013. Resident #013 had a identified wound to a specific body area. Resident #013 dressing was changed on an identified date. Due to a Treatment Administration Record (TAR) error, it was not changed again until 41 days later. The resident's wound deteriorated during this time.

In an interview on an identified date, Manager of Resident Care (MRC) #119 explained that on the identified date, Registered Practical Nurse (RPN) #128 entered a treatment order for Resident #013. The treatment order read "Monitor dressing to the specific body area daily. Dressing to be changed on an identified day following bath. Cleanse with normal saline and cover with an identified ADHESIVE". MRC #119 explained that RPN #128 selected 'standard' order instead of 'TAR' from a drop down menu when submitting the treatment order. Because of this error, the treatment order RPN #128 entered did not get transcribed to resident #013's TAR.

In an interview on an identified date, Director of Clinical Practice (DCP) #125 also confirmed with Inspector #732 that RPN #128 did not choose 'TAR' from the drop down menu when submitting the treatment order. Therefore, the treatment order RPN #128 entered did not get transcribed to resident #013's TAR.

Inspector #732 reviewed resident #013 care plan on Point Click Care (PCC). Resident #013's care plan, completed on an identified date, documents that resident #013 had a wound to a specific body area. Interventions included: apply wound dressing as needed, and completely off-load the areas in all positions.

Inspector #732 reviewed resident #013's Treatment Administration Record (TAR) on PCC. The TAR for the identified month had the last weekly wound assessment and dressing change signed off as completed on the identified date. The TAR for the next month, shows no order to monitor dressing to the identified body area, instructions on how to change the dressing, or the frequency of the dressing change. It does not include the weekly wound assessment.

MRC #119 told Inspector #732 on the identified date, that the error was

discovered on 41 days later. MRC #119 confirmed that the dressing to resident #013's identified body area was dated on the identified date, upon discovery of the error. MRC #119 confirmed that weekly wound assessments, dressing changes, and daily monitoring, was not completed for resident #013 wound for 41 days as the order was not transcribed properly to the TAR.

The licensee failed to ensure that the care set out in the plan of care for resident #013 wound was provided as specified in the plan. [s. 6. (7)]

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

This finding is related to Intake Log #033450-18

The Critical Incident Report (CIS) indicated that resident #012 closed an area to prevent resident #011 entering the area on an identified date. The fixture hit resident #011‘s device and as a result, resident #011 fell.

Review of the resident’s physician order on an identified date, indicated to implement behavior mapping for one week.
The behavior mapping that had started on an identified date, revealed that multiple hours during identified dates were not documented.

In an interview with PSW #157 on an identified date, they indicated that the resident was monitored every hour but the behavior mapping was not documented for an identified date, during a specific shift.

In an interview with PSW #158 on an identified date, they stated that resident #012 sleeps well during the night and the behavior mapping form was not documented for two days, during a specific shift.

In an Interview with PSW Supervisor #130 on an identified date, they outlined that PSW #139 was the staff taking care of resident #012 on an identified date and no behavioral mapping form was completed on that date. The PSW Supervisor #130 indicated that the behavior mapping should be completed by the PSW every hour to monitor the resident’s behaviors. [s. 6. (9)]

3. This finding is related to Intake Log #022116-18

The Critical Incident Report (CIS) indicated that resident #026 had responsive behavior toward resident #027 on an identified date.

Review of the resident's physician order on the identified date, indicated that the behavior mapping should be started.

Review of resident #026's behavior mapping for six identified dates during specific times were not documented.

Inspector #211 was unable to reach the PSWs who were responsible for the behaviour mapping for resident #026 to obtain the reason the behavior mapping form was not completed on the above noted shifts.

In an interview with the Manager, Resident Care #119, they stated that the behavior mapping needs to be documented by the staff to evaluate the resident's behaviours.

The licensee has failed to ensure that the behavior mapping for resident #012 and resident #026 were documented. [s. 6. (9)]

4. The licensee has failed to ensure that resident #018 is reassessed and the plan of care reviewed and revised when, (b) the residents care needs change or care set out in the plan is no longer necessary.

A review of resident #018's written plan of care on an identified date, found the following goal and interventions:
Goal- To prevent physical and emotional harm to resident.

Interventions- Do not leave resident unattended in the hallway. Supervise their commute to/from the dining room and their room.
Observations by Inspector #593, found the following:

On an identified date, 1150 – 1205 hours: Resident #018 was observed seated in the hallway of the unit. Resident #018 was unattended.

The next day, 1120 – 1130 hours: Resident #018 was observed seated in the hallway of the unit with another resident. PSW #132 left the area during this time

and resident #018 was left unattended.

On the above same day, 0935 – 0950 hours: Resident #018 was observed in the hallway, they were ambulating with a device. During this time, the staff were in an identified area room attending to other residents. Resident #018 was unattended.

During an interview with Inspector #593, on an identified date, PSW #132 indicated that they were unaware of the intervention "do not leave resident unattended in a specific area", and that resident #018 can be left alone in the area and ambulate unattended. PSW#132 added that resident #018 interacts pleasantly with other residents on the unit.

During an interview with Inspector #593, on an identified date, PSW #162 indicated that resident #018 can be left alone, they wander the hallway and it is safe for them to do so.

During an interview with Inspector #593, on an identified date, RPN #127 indicated that resident #018 wanders throughout the unit and if the resident becomes agitated, we try to keep them away from others. We also take them to the specific room, so that no other residents are around them or we take the resident to their room, which is a safe place for them.

During an interview with Inspector #593, on an identified date, RN #126 indicated that resident #018 was monitored for aggressive behaviors, we try to keep them so that they are not in the specific area and the resident is moved from the areas where they cannot reach out and grab other residents.

During an interview with Inspector #593, on an identified date, Manager of Resident Care (MRC) #119 indicated that resident #018 does not require this (referring to care plan documented above) intervention at the moment. They added that the staff look for triggers, if they see the resident becoming agitated, they know they need to be more observant and escort the resident to and from the specific room. MRC #119 indicated that they updated the written plan of care to read "Do not leave resident unattended in the specific area, supervise their commute to/from the specific area and their room when they are seeking out other residents, calling out for help".

Resident #018 has a history of responsive aggressive behaviors towards other residents in the home. As a result, the written plan of care had interventions to

manage this. Multiple staff were not aware of this intervention with the Manager of Resident Care #119, indicating that this intervention was not accurate and need to be revised. As a result, the licensee has failed to ensure that resident #018 was reassessed and the plan of care reviewed and revised when the care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the following are documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the act or regulation requires a licensee of a long-term-care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

This finding is related to intake Log #020194-18

In accordance with O.Reg 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including skin and wound care, required under section 48 of this Regulation that included relevant policies to promote skin integrity, prevent the development of wounds and pressure ulcers, and treatments and interventions.

Specifically, staff did not comply with the Licensee's policy titled 'Skin and Wound Care Program' revised on an identified date, which is part of the Licensee's skin and wound care program.

On an identified date, Director of Clinical Practice (DCP) #125 gave Inspector #732 the home's policy and procedure surrounding the Skin and Wound Care Program. Inspector #732 reviewed the policy issued February, 2007, and revised revised April 11, 2018. It was titled 'Skin and Wound Care Program.

Under policy, it stated that any resident who has a wound will be :
a. Assessed by a registered staff using the weekly wound assessment tool
b. Reassessed at least weekly by a registered staff member as clinically indicated

It also stated, a plan of care will be documented in the Electronic Health Record (EHR) to reflect the resident's goals of care related to skin and wound, interventions, and treatments.

Under procedure it stated, a resident exhibiting altered skin integrity, inlcuding skin breakdown, pressure ulcers, skin tears or wounds will have :
• A weekly wound assessment completed by the registered staff using the weekly wound assessment tool under the assessment tab in Point Click Care (PCC);
• A photo of the wound, by the registered staff, saved in Point Click Care (PCC) under the "Documents" tab
• Immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required;
• Changes to interventions (by the appropriate team member) and the resident's plan of care as appropriate

Appendix A of the policy and procedure is entitled "Interprofessional Team

Responsibilites"

The responsibility of Registered Staff is listed as follows:
• Complete skin assessments as outlined in the Skin and Wound Care Program Policy and Procedure
• Implement an individualized plan of care
• Complete weekly wound assessments including a photo of the wound
• Enter into the Treatment Administration Record (TAR) the current treatment plan

An identified CI was submitted to the Director in regards to improper/incompetent treatment of a resident that resulted in harm or risk of harm to resident #013. Resident #013 had a wound on an identified body area. Resident #013 dressing was changed on a specific date. Due to a Treatment Administration Record (TAR) error, it was not changed again until 41 days later. The resident's wound deteriorated during this time.

In an interview on an identified date, Manager of Resident Care (MRC) #119 explained that on the specific date, Registered Practical Nurse (RPN) #128 entered a treatment order for Resident #013. The treatment order read "Monitor dressing to the specific body area daily. Dressing to be changed on an identified day of the week following bath. Cleanse with normal saline and cover with a specific ADHESIVE". MRC #119 explained that RPN #128 selected 'standard' order instead of 'TAR' from a drop down menu when submitting the treatment order. Because of this error, the treatment order RPN #128 entered did not get transcribed to resident #013 's TAR.

On January 23, 2019, RPN # 124 confirmed that 'TAR' needs to be selected when creating a treatment order for the order to be entered into the Treatment Administration Record (TAR)

In an interview on an identified date, DCP #125 confirmed with Inspector #732 that RPN #128 did not choose 'TAR' from the drop down menu when submitting the treatment order. The treatment order RPN #128 entered did not get transcribed to resident #013's TAR.

Therefore, the registered staff responsibility to enter into the TAR the current treatment plan, as stated in Appendix A of the Skin and Wound Care Program Policy and Procedure, was not followed.

On an identified date, Inspector #732 reviewed resident #013 assessments on Point Click Care (PCC). A Weekly wound Assessment was completed for resident #013 on a specific date. The next Weekly Wound Assessment for resident #013 was not completed until 41 days later.

In an interview on an identified date, DCP #125 confirmed that resident #013 did not receive weekly wound assessments until the error was discovered 41 days later. DCP #125 confirmed with Inspector #732 the expectation that resident #013 should have received weekly wound assessments during that time.

In an interview on January 22, 2019, MRC #119 confirmed that weekly wound assessments were not completed for 41 days.

On an identified date, Inspector #732 reviewed resident #013 documents on PCC. A photo of resident #013's wound was uploaded on an identified date. The next photo uploaded of resident #013's wound was not until 41 days later. Therefore, the responsibility of registered staff, in Appendix A of the Skin and Wound Care Program Policy and Procedure, was not followed.

The licensee failed to ensure that the home's Skin and Wound Care Program Policy and Procedure was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. This finding is related to Intake Log #020710-18.

The licensee has failed to ensure that the home's policy "Fall Prevention Program policy on an identified date", was complied with.

According to O. Reg 79/10, s. 48 (1) 2, every licensee of a long-term-care shall ensure that the following interdisciplinary programs is developed and implemented in the home; 1. A falls prevention and management program to reduce the incident of falls and the risk of injury.

In accordance with O.Reg 79/10, s. 30 (2), the licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to intervention are documented.

A review of the home's Fall Prevention Program policy on the identified date, indicated that the staff shall complete the Post-Fall Assessment within 24 hours

after a resident's fall as followed:
a. Provide comfort and reassurance to the resident.
b. Rule out injury by completing a physical assessment.
i. If the resident is on the floor, assess the resident while on the floor first and then move the resident using a mechanical lift.
ii. Reassess the resident once they are returned to bed.
iii. Complete vital signs. Blood pressure should be assessed in both sitting and standing position if possible.
iv. If the resident has hit their head, complete the neurological assessment as per the policy
c. Complete the Scott Fall Risk Screen to assess a change in fall risk.
d. Complete the post-fall huddle and mini-root cause analysis, with all members of the inter-professional team available, including the resident/family and substitute Decision Maker (SDM) where possible.

The CIS indicated that resident #015 had a fall on a specific date and was sent to the hospital on the same day.

Review of resident #015's health care records indicated that resident had two falls for two specific months within a period of six months.

Review of resident #015's progress notes indicated the licensee was informed by the hospital on an identified date, that the resident sustained an injury. The next day, the licensee was notified that the resident was returning to the home.

Review of the Post fall Assessment on an identified date, indicated that a post-fall huddle and the physical Assessment were completed.

Review of the Post Fall Assessment for the next fall on the identified date, indicated that the post huddle was completed.

Interview with the Manager, Resident Care #119 stated that the Post Fall Assessment included the Post-Fall huddle, the physical assessment and the Scott Fall Risk Screen needs to be completed after a resident fall. The Manager, Resident Care #119 stated that the post-fall huddle and the physical assessment were completed for resident #015's fall on the identified date. However, the Scott Fall Risk Screen was not completed. The Manager, Resident Care #119 indicated that only the post-fall huddle was completed for resident #015's fall on the other identified date. The Manager, Resident Care #119 stated that the physical

assessment and the Scott Fall Risk Screen were not completed. The staff did not follow the home's Fall Prevention Program policy.

The licensee has failed to ensure that the home's Fall Prevention Program policy and a procedure was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Skin and Wound Care and the home's Fall Prevention Program policies and procedures were complied with., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report. 4. i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), on an identified date reporting the alleged abuse of resident #002 by resident #001. It was reported in the CIS that resident #002 was in the room of resident #001, resident #002 screamed and ran out of resident #001's room. Resident #002 was assessed and noted an identified injury to a specific area of the body area.

As per the CIS, the incident occurred on an identified date during the evening shift. The CIS was submitted two days later and the after-hours pager was called on the same day of the incident during the evening shift. The CIS initially submitted two days later did not include the analysis and follow up including the immediate actions to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence. The CIS was amended on an identified date with this information, 43 days after the CIS was initially submitted.

During an interview with Inspector #593, on the identified date, Manager of Resident Care (MRC) #151 indicated that the CIS was not completed in full as they may have missed the request for an amendment and the CIS was not completed in time initially as the information was not available (log #027482-18). [s. 104. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report. 4. i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion of abuse of a resident by anyone and the information upon which it was based to the Director.

This finding is related to Intake Log #031713-18

A critical incident report was submitted to the Director related to the alleged abuse

of a resident #009 by a staff member of the home.

A review of the CIS Report indicated that the CI date and time was on the identified date. The date and time the CI was first submitted to the Director was the next day.

In an interview with Manager of Resident Care #107 on an identified date, they confirmed to Inspector #733 that they did not consider using the after hours pager to notify the Director of the incident on the same day that it had occured. Instead, they completed the CIS Report the next day.

The Director was not immediately notified of this incidence of alleged abuse of a resident. [s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to resident #003, has immediately reported the suspicion and the information upon which it is based to the Director.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), on an identified date reporting the witnessed abuse of resident #003 by resident #001. It was reported in the CIS that resident #001 struck out when approached by resident #003. Resident #003 sustained two small abrasions to an identified date.

As per the CIS, the incident occurred on an identified date; however was not reported to the Director until the next day. The following was documented in the CIS: Please note that RPN working on unit was new and failed to contact the admin on call so that MOHLTC after hour's pager could not be notified.

During an interview with Inspector #593, on an identified date, Manager of Resident Care (MRC) #151 indicated that the CIS was not reported immediately as RPN #113 did not notify the Admin on call. It is the Admin on call who will contact the Director via the after-hours pager or direct the charge RN to do so. MRC #151 indicated that RPN #113 was re-educated on the home's reporting policy (log #026503-18). [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This finding is related to Intake Log #020194-18.

An identified CI was submitted to the Director in regards to improper/incompetent treatment of a resident that resulted in harm or risk of harm to resident #013.Resident #013 has a wound to a specific body area. Resident #013 dressing was changed on an identified date. Due to a Treatment Administration Record (TAR) error, it was not changed again until 41 days later. The resident's wound deteriorated during this time.

On the identified date, Registered Practical Nurse (RPN) #128 incorrectly entered a treatment order for resident #013. Due to this error, weekly wound assessments were not added to the Treatment Administration Record (TAR) for resident #013, and therefore were not completed until the error was discovered 41 days later.

On an identified date, Inspector #732 reviewed resident #013 assessments on Point Click Care (PCC). A weekly wound Assessment was completed for resident #013 on an identified date. The next weekly wound assessment for resident #013 was not completed until 41 days later.

In an interview on an identified date, Manager of Resident Care (MRC) #119 confirmed that weekly wound assessments were not completed for 41 days.

In an interview on an identified month in 2019, Director of Clinical Practice (DCP) #125 confirmed that resident #013 did not receive weekly wound assessments until the error was discovered 41 days later. DCP #125 confirmed with Inspector #732 the expectation that resident #013 should have received weekly wound assessments during that time.

The licensee has failed to ensure that resident #013 was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Issued on this 14th day of March, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 (ID #) / Nom de l'inspecteur (No) :	Amended by JOELLE TAILLEFER (211) - (A1)
Inspection No. / No de l'inspection :	2019_618211_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008098-18, 008850-18, 010656-18, 011657-18, 020194-18, 020710-18, 022002-18, 022116-18, 022120-18, 023291-18, 026503-18, 027110-18, 027482-18, 028225-18, 028994-18, 029414-18, 031713-18, 032020-18, 032353-18, 033203-18, 033450-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 14, 2019(A1)
Licensee / Titulaire de permis :	The Perley and Rideau Veterans' Health Centre 1750 Russell Road, OTTAWA, ON, K1G-5Z6
LTC Home / Foyer de SLD :	The Perley and Rideau Veterans' Health Centre 1750 Russell Road, OTTAWA, ON, K1G-5Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Akos Hoffer

To The Perley and Rideau Veterans' Health Centre, 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

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee shall ensure that:

1. High intensity monitoring for thirteen hours on the prearranged specific times, is provided to resident #001 as per the plan of care and hours are reviewed weekly and adjusted as needed to ensure that residents in the home are protected from abuse by resident #001.

2. Re-education is provided to PSW and registered nursing staff working on the identiifed unit, on the specific requirements associated with the provision of high intensity monitoring for resident #001, including but not limited to:
• Ensuring that the assigned high intensity staff member:

o Does not leave resident #001 to assist other staff or residents.
o Does not leave resident #001 at shift end until another staff member is available for the high intensity monitoring.
o Continues to monitor resident #001 when family or friends are visiting, while still respecting the resident's privacy.
o Monitors resident #001 for thirteen hours on the prearranged specific times daily and if late arriving to the unit, informs to the registered nursing staff or unit manager, so that alternate coverage can be arranged.
o Heightened monitoring when resident #001 is in high identified areas. Redirecting residents from wandering into resident #001's personal space.

3. The training completed must be documented including who completed the training, when the training was completed, and what was included in the training including who the trainer was.

Grounds / Motifs :

(A1)
1. 1. The licensee has failed to ensure that residents of the home are protected from physical abuse by resident #001.

This finding is related to Intake Log #026503-18.

Under O.Reg. 79/10, 2. (1) For the purposes of the definition of "abuse" in subsection

2 (1) of the Act, "physical abuse" means, subject to subsection (2),

(c) the use of physical force by a resident that causes physical injury to another resident".

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date reporting the witnessed physical abuse of resident #004 by resident #001. It was reported in the CIS that resident #001 was holding on resident #004 and was hitting them. Resident #004 sustained an injury.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), one month later, reporting the witnessed physical abuse of resident #003 by resident #001. It was reported in the CIS that resident #001 struck out when approached by resident #003. Resident #003 sustained two small injuries.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), the next month, reporting the alleged physical abuse of resident #002 by resident #001. It was reported in the CIS that resident #002 was in an identified area with resident #001, resident #002 screamed and ran out from the area. Resident #002 was assessed and noted an injury to a specific area of the body.

Inspector #593 reviewed resident #001's progress notes and found 32 documented incidents of physical aggression with contact and 3 physical abuse towards co-residents in the home including the CIS reports detailed above. Following are the incidents that occurred over the past six months, prior to this there were other multiples documented incidents within two months.

On an identified date during the morning hours- resident #001 grabbed resident #029 when they approached them in an identified area.

The previous month during the evening hours- resident #001 punched resident #029. PSW #157 reported being in another resident's room trying to redirect resident when co-resident entered. PSW #157 was unable to intervene in time when resident #001 punched co-resident.

On the same day during the afternoon hours- the high intensity monitoring PSW

#158 reports that resident #001 was approached by resident #030 in a specific area at lunchtime. Resident #001 grabbed onto co-resident's identified body area.

On another previous month during the morning hours- Resident #030 was walking in the hallway in front of an identified room, touched resident #001 and poured some identified liquid on them. Resident #001 was upset and grabbed resident #030 and held them very tight. RPN #156 turned around, saw the action, and separated both residents.

The other previous month during the evening hours- Resident #001 was seated in a specific area when resident #031 approached to sit down at seat near resident #001. Resident #031 placed their right hand on table when sitting down. Resident #001 became agitated and grabbed resident #031's identified body area and squeezed. Resident #031 began vocalizing loudly and became visibly agitated. PSW #155 providing high intensity monitoring was asked what happened and they replied "I don't know".

Nine days prior the above incident during the evening hours- PSW reported that resident #002 screamed and ran out of resident #001's room. Resident #002 was assessed and noted an injury to a specific body area (submitted as a CIS).
Six days prior the above incident during the evening hours- Resident #001 was sitting in a specific area when resident #030 walked by and approached resident #001. Resident #001 grabbed resident #030. RPN #113 reported that it appeared resident #001 was trying to injure the other resident.

On another identified month during the evening hours- Resident #001 was seated on a chair at an identified area, resident #003 approached carrying an item and placed the item on resident #001's lap. Resident #001 struck out at resident #003 and spoke to resident #003 in a angry voice while attempting to strike out at resident. Resident #003 had an injury and the area was treated (submitted as a CIS).

Three days prior the above incident during the day hours- Resident #001 was in an identified area eating, resident #032 approached them and reached for the food. Resident #001 grabbed resident #032 and hit them in an identified area of the resident's body.

On the same day, five minutes prior the other incident- Resident #001 grabbed

resident #033 as they were ambulating past the resident's specific area. Resident #033 attempted to pull away, however resident #001's grip was too strong and the PSW had to intervene.

Twelve days prior the above incident during the evening hours- Resident #031 had a fall and was calling out, resident #001 got out of their chair and walked over to resident #031 and hit the resident on a particular body area while talking to them.

One month prior the above incident during the evening hours- Resident #001 grabbed resident #130. Unwitnessed by staff who were in the dining room at that time. Staff were able to separate residents from each other.

One day prior the above incident during the evening hours- RPN #159 heard a noise from resident's room. PSW #115 was in another resident's room when they went in to check trying to separate resident #001 and resident #002. Resident #001 had grabbed resident #002 with an angry look on their face.

On the same day, Resident #002 walked by resident #001 and stated "that's mine" and pointed to an item. Resident #001 grabbed resident #002 and pulled the resident towards them self as they walked by. It was reported that it was difficult to redirect resident #001 away from resident #002 with a second staff member required.

Three days prior the above incident during the evening hours- At approximately one hour prior the incident, resident #001 was in a specific area. Resident #034 was being escorted to the specific area and crying loudly. Resident #001 asked the PSW to "quieten down your buddy". Resident #001 moved toward resident #034 and grabbed the back of the resident's clothes.

Eight days prior the above incident during the evening hours- Earlier during the evening shift, resident #030 approached resident #001 and reached to touch them. Resident #001 grabbed resident #030 and twisted body area slightly.

Two days prior the above incident during the evening hours- Resident #001 was physically aggressive towards resident #002. Resident #001 was holding resident #002's specific body area and tried to squeeze it. Resident #001 stated that resident #002 came into a specific area and they see what happens".

On day prior the above incident during the late evening hours- Three hours earlier, resident #030 approached resident #001 and entered their personal space. Resident #030 reached out to grab resident #001. Resident #001 grabbed resident #030 and yelled. Resident #001 observed to have an angry facial expression. Staff attempted to remove resident #001's hands from resident #030's specific body area but they had a firm grip and initially refused to let go. Staff were then able to get resident #001 to let go and they were redirected to their room.

Two days prior the above incident during the early afternoon- Resident #001 was sitting in a specific area with both of their hands grabbing the clothes of resident #004. Resident #001 hit them in a specific body area. There was a small amount of an injury on resident #004 on two specific body areas (submitted as a CIS).

Five days prior the above incident during the evening shift- At a identified hours, a PSW reported that resident #001 grabbed resident #030 and when the PSW intervened, resident #001 punched resident #030 on an identified body area. As per the PSW, resident #030 was trying to lean towards resident #001 and touched in a specific way.

On the same above day during the morning shift- After meal, resident #001 went back to their room, they quickly started grabbing and punching resident #035. Resident #035 had entered resident #001s personal space, who responded by punching resident #035.

Three days prior the above incident during the evening hours- Resident #001 was seated when another resident approached them and touched resident #001's identified body area. Resident #001 grabbed co-resident.

Two days prior the above incident during the evening shift- Resident #030 approached resident #001 in a specific area. Resident #001 grabbed resident #030, resident #001 had a mad facial expression.

Resident #001 was admitted to the home in an identified date.

A review of resident #001's current care plan on an identified date, documented the following focus and interventions:

Focus: High intensity needs during high risk times for specified times on a daily basis.

Interventions:
• Continuous high intensity needs monitoring for identified times on a daily basis. Registered Staff are to assess the need of high intensity monitoring at other times when resident is awake.
Resident does not like to be approached by co-residents; redirect co-residents from approaching resident. Staff to stand between co-residents and resident.

Focus: Verbal/physical responsive behaviour as evidenced by (hitting, pushing staff and co-residents) related to: Cognitive impairment.

Interventions:
• High intensity monitoring support as preventative measure to help minimize interactions with co-residents.
• Monitor, document and report responsive behaviour.
• Closely monitor resident and redirect the resident away from co-resident's in identified rooms due to previous physically aggressive incidents with.

A review of resident #001's progress notes indicated that increased monitoring, through high intensity monitoring of resident #001 was initiated four months after the admission. Progress notes indicate that the high intensity monitoring was put into place for seven identified hours per day. One month later, the high intensity monitoring hours were increased to thirteen hours daily.

A review of resident #001's physician's orders found the following documented orders:

• On an identified date- High intensity monitoring for eleven identified hours. To be reassessed after behaviour therapy assessment report and recommendations are available.
• Seven day later- Continue high intensity needs extra staff to minimise risk of harm to others.
• Fourteen weeks and three days later- Continue high intensity needs for thirteen identified hours daily.
• Seven days later- Continue high intensity needs for thirteen identified hours.

• Seven days later- Continue the high intensity for the same above hours.
A review of resident #001's health care record found a high intensity monitoring guidance document, a summary of the document follows:
• Resident #001 is on high intensity monitoring because they are irritated by co-residents and will grab or hit them.
• Triggers:
o Co-residents entering residents #001's personal space
o Co-residents touching resident #001 or their personal device.
o Co-residents vocalising near resident #001
• PSW is to keep co-residents away from resident #001 (especially the nine identified residents).
• Resident #001 can very quickly and unpredictably grab a co-resident that walks by them.
• High risk are in two identified areas. Encourage resident #001 to move out of these areas.
• High risk times are for the nine identified hours.
• If resident #001 is in their room, PSW can be in hall but must closely monitor the door to ensure co-residents do not enter.

During the inspection, Inspector #593 observed the following:

On an identified date,

During a morning time- Resident #001 was observed in the identified area after a specific post meal. Resident #002 was seated in an armchair across from resident #001. The high intensity monitoring staff was not present.

Six minutes later- Resident #001 remains seated in the identified area. Resident #002 was seated in an armchair across from resident #001. The high intensity monitoring staff was not present.

Five minutes later- PSW #115 arrives and interacts with resident #001. PSW #115 confirms that they were resident #001's high intensity monitoring until an identified change of shift.

Six minutes later- PSW #115 cleared resident #001's dishes to an identified area, then washed their hands before returning to resident #001.

Two minutes later- PSW #115 wiped down resident #001's table, returned to the identified area, washed their hands before returning to resident #001. Resident #002 remained seated across from resident #001.

Two minutes later- PSW #115 leaves resident #001 to assist resident #029, entered the charting room/nurses station and then returned to resident #001.

Four minutes later- PSW #115 removed resident #001's appliance, takes the appliance to the identified area, washed their hands and then returned to resident #001.

Five minutes later- Resident #029 was hovering around resident #001, PSW #115 redirected the resident, then left for another identified area to wash their hands. While PSW #115 was in the identified area, resident #029 returned to the side of resident #001.

Seven minutes later- Resident #002 was observed to approach resident #001, PSW #115 was observed to redirect the resident away from resident #001. PSW #115 indicated that resident #002 liked to touch other resident's identified body area, including resident #001.

The next day

During the early afternoon- Resident #001 was observed in the identified room area during an identified meal service. PSW #114 was observed to take resident #001 back to their room and then return to the identified room. A family member was observed to be visiting with resident #001.

Five minutes later for approximately four minutes- PSW #114 returned to the units corridor, however was observed in resident #036's doorway. PSW #160 had asked PSW #114 to stand by resident #036's door as resident #036 keeps leaving their room. PSW #114 was observed to follow this request. PSW #160 leaves to return to the identified room area. There was no high intensity monitoring with resident #001 during this time.

At approximately two hours later- Inspector #593 was interviewing PSW #114,

during that time when PSW #114 realised that their shift had finished, they quickly left the unit and resident #001 was left with no high intensity monitoring. On the identified shift staff were observed at the end of the corridor doing handover, the staff were discussing which PSW was going to monitor resident #001. Three residents were observed actively wandering by resident #001's room at specific time.

- On an identified shift handover ends and PSW #161 joined resident #001 for the high monitoring.

- On another shift, Inspector #593 entered the corridor of the unit and PSW #161 was not with resident #001. Resident #001 was observed to be in their room with the door closed. PSW #161 was observed at the other end of the corridor. Three residents were observed actively wandering by resident #001's room at this time. PSW #161 sees Inspector #593 standing by resident #001's doorway and returns to this area, telling the Inspector "I have been checking on resident #001 every 10 minutes".

During an interview with Inspector #593, on an identified date, PSW #116 indicated that the role of the high intensity monitoring PSW was to ensure that they have no confrontations with other residents as resident #001 was very unpredictable, "we try to keep the resident busy". Resident #001 does not like other residents in their room, they wander and we have to keep the other residents safe. Resident #001's demeanor changes when another resident approaches, when resident #001 is in an open area and a resident walks by, resident #001 reacts quickly, we have been told not to turn our backs for even two seconds as some of the residents are pretty quick.

During an interview with Inspector #593, on an identified date, PSW #115 indicated that resident #001 requires high intensity monitoring as they are responsive to other residents who are vocalising or in their personal space. Other residents needed to be redirected from resident #001 as they will strike out at other residents. PSW #115 added that resident #001's behaviours do not escalate, it's like hitting a switch, and the resident goes from being nice to striking out trying to punch or kick at staff and residents. PSW #115 indicated that the high intensity monitoring begins at a specific time during the morning and that the timing is strict. PSW #115 said that there have been incidents with both resident #002 and #029 as both of these residents wander into residents #001's personal space and resident #029 is very vocal which is a trigger for resident #001.

During an interview with Inspector #593, on an identified date, PSW #114 indicated that the role of the high intensity monitoring's PSW was to prevent resident #001 having interactions with other residents, keep resident #001 occupied and busy with activities and to redirect other residents away from resident #001. Resident #001's triggers included residents who are too verbal and residents that approach resident #001, we can see resident #001 becoming agitated and they will strike out or grab a co- resident and pull them in. PSW #114 indicated that when resident #001 has a visitor, the high intensity monitoring remains but they will stand by the residents door to their room and make sure no other residents try to enter their room.

During an interview with inspector #593, on an identified date, PSW #112 indicated that resident #001 has a high intensity for monitoring as they get agitated, they will grab and pull onto another resident, the high intensity monitoring PSW is there to intervene. There are more behaviours from resident #001 in the afternoon for 2 hours, as the other residents on the unit are more active and vocal. PSW #112 added that resident #001 was more verbally responsive towards specific residents, and they are more likely to lash out at these residents than other resident and if they are really agitated, they will reach out for residents wandering past. When the resident is in bed, the role of the high intensity monitoring PSW is to prevent other residents from entering their room.

During an interview with Inspector #593, on an identified date, RPN #113 indicated that resident #001 was aggressive towards other residents, if another resident reaches out for them or anytime someone walks by slowly or if they are talking near him, resident #001 will grab them. RPN #113 added that resident #001's behaviour changes very quickly, and other residents are a trigger. The role of the high intensity PSW is to ensure that co-residents can pass safely in the corridor, if other residents are making noise, which they often are, resident #001 will head toward the noise because they are upset, the high intensity monitoring PSW is supposed to redirect them.

During an interview with Inspector #593, on an identified date, RN #111 indicated that resident #001 was triggered by co-residents coming near them, if they are vocalising or they don't make sense, this really irritates them. Resident #001 will reach out and grab them. RN #111 added that resident #001 needs high intensity supervision because the psychiatrist said that there was no medication that can address this behavior, nothing can stop them from being irritated by their co-

residents and in this environment, there are many residents wandering and talking, speech is disorganised. The high intensity monitoring is to keep other residents safe, they are to redirect other residents away if they approach or try to enter resident #001's room. RN #111 further indicated that the high intensity PSW should not be leaving resident #001 alone as there were a few instances when resident #001 was sitting away from the other residents in the dining room, the high intensity staff brought their dishes to the kitchen and during this time, resident #029 walked up and resident #001 grabbed them, it happened so quickly. RN #111 added that resident #001 will get territorial about a spot, they won't move if they are irritable, that's why the identified area room is not good for resident #001, as it is such a high traffic area.

During an interview with Inspector #593, on an identified date, Manager of Resident Care (MRC) #151 indicated that the high intensity monitoring started near the beginning of an identified month for eight hours and was increased to thirteen hours for the next month. MRC #151 said that the high intensity staff is usually a PSW, if it is not a PSW, then it is an RPN and their role is to monitor the resident in their room, they are making sure no other residents are going into their room. If resident #001 is out of their room, the high intensity staff is redirecting other residents away from resident #001 as resident #001 is reactive of other residents in their personal space. The high intensity staff is resident #001's shadow. In response to the incidents that occurred when the high intensity monitoring was in place, MRC #151 indicated that they did re-education with the staff, we told them you cannot take your eyes off resident #001 for a second. MRC #151 added that resident #001 can be calm and pleasant and then a resident walks past and resident #001 changes very quickly. MRC #151 said that they also have a one page document for staff to refer to which are the responsibilities of the high intensity staff (as described above). MRC #151 confirmed that when a family member was visiting resident #001, the high intensity monitoring was still in effect.

Resident #001 has had 32 documented incidents of physical aggression with contact and 3 incidents of physical abuse towards other residents on the identified unit. Three of these incidents resulted in injury to co-residents. In a specified month, a high intensity monitoring was implemented during the afternoon for eight hours for resident #001 to protect the other residents on the unit, after further incidents, these hours were extended to thirteen hours. Despite, the high intensity monitoring, five additional incidents occurred where resident #001 was able to make physical contact, and inflict force on other residents. During the inspection, Inspector #593

observed on multiple occasions, resident #001 without their high intensity monitoring staff between an identified times for thirteen hours. Resident #001's plan of care documented that they are required to have high intensity monitoring for other residents safety during this time. During these observations, residents involved in previous incidents were allowed to enter resident #001's personal space as the assigned high intensity monitoring was not monitoring the resident. As such, the licensee has failed to ensure that residents of the home are protected from physical abuse by resident #001.

The licensee failed to comply with:

1.LTCHA s. 24 (1) 2. A person who has reasonable grounds to suspect abuse of a resident by resident #001 that resulted in harm or risk of harm, shall immediately report the suspicious and the information upon which it is based to the Director. (Refer to WN #4)

2. O. Reg 79/10 s.104. (1) 4. The licensee shall include in a making of a report to the Director under subsection 23 (2) with respect to the alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone, the following material in writing:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence,
ii. the long-term actions planned to correct the situation and prevent recurrence. (Refer to WN #6)

The decision to issue a compliance order was based on the severity of the issue, 32 physical aggression with contact toward residents and 3 physical abuse towards other residents in the home as well as the scope of the issue, 32 documented incidents of physical aggression with contact and 3 incidents of physical abuse by resident #001. The home had a level 2 compliance history as they had a past unrelated previous non-compliance. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 14th day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOELLE TAILLEFER (211) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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