Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_601532_0008	013365-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
959 9th Avenue East OWEN SOUND ON N4K 3E3

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

ROCKWOOD TERRACE HOME FOR THE AGED
575 SADDLER STREET EAST P. O. BOX 660 DURHAM ON N0G 1R0

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

NUZHAT UDDIN (532), APRIL TOLENTINO (218), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4, 5, 6, 7, 11, 12, 13, 14, 17, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):
Critical Incident Log #026620-16 related to falls prevention;
Critical Incident Log #032211-16 related to alleged abuse;
Critical Incident Log #004948-17 related to alleged abuse;
Critical Incident Log #002171-17 unexpected death;
Critical Incident Log #003643-17 alleged abuse;
Critical Incident Log #004654-17 alleged abuse;
Critical Incident Log #007405-17 alleged abuse;
Critical Incident Log #011245-17 alleged abuse.

Complaint Log #009757-17 related to responsive behaviours;
Complaint Log #009051-17 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Personal Support Worker Coordinator, Registered Dietitian, Building Services Manager, Resident Assessment Instrument (RAI) Coordinator, Behaviour Support Ontario Staff (BSO), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aide, Recreation Care Aide, Housekeeping and Maintenance staff, Family, Resident Council Representatives, and over forty residents.
Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

The Critical incident report submitted to the MOHLTC documented that two identified residents fell and were both assisted by staff. The alleged staff member was notified of both incidences but neglected to complete an appropriate post-fall assessments and report the incidences to the oncoming nursing staff member.

A record review of the LTCH's policy titled "Falls Prevention", documented that when a fall occurred, all staff will "ensure the resident is not moved prior to the completion of a preliminary assessment".

In an interview DOC stated that the identified staff involved in the incidences should have waited for a nurse to complete an assessment prior to moving the identified residents.

The "Falls Prevention" policy also documented that the registered staff was responsible for completing an electronic post-falls assessment when a fall occurred. There was no documentation or post-fall assessments completed for the falls incidences involving the identified residents.

In an interview an identified registered staff stated that they completed the post-fall assessments upon becoming aware of the falls incidences.

A review of these post-fall assessments indicated that there was an injury for one of the identified resident involved in the fall.

An identified registered staff stated that the expectation was to immediately assess the resident for every incident in which a resident falls.

Subsequently, a CI report submitted to the MOHLTC documented that an identified resident was left to wait alone for an extended period of time until assistance was provided.

A record review of the resident plan of care documented interventions related to the identified residents' risk for falls.

A review of a specified report demonstrated that the resident was left unattended for an extended period of time until assistance became available. DOC acknowledged that this incident placed the resident at risk for harm and that it was unacceptable and neglectful practice by staff.

The licensee failed to provide residents with treatment, care, services and assistance related to falls as evidenced by the pattern of inaction that jeopardized the safety of the residents.

b) The Critical Incident (CI) submitted to the Ministry of Health and Long-Term Care (MOHLTC), documented an incident of abuse. The incident was witnessed by two additional staff members who were interviewed and corroborated the story.

A review of the plan of care for the identified resident stated that the resident had an impairment and listed the interventions for staff to follow related to the specified impairment.

A progress note stated that the resident expressed feelings of fear immediately following the incident.

Both staff members that were present during the event verified the incident.

An identified staff stated that they received report from the two witnesses involved and considered the situation to be abusive in nature.

DOC stated that the outcome of the internal investigation demonstrated that the witnesses' statements aligned with one another. DOC acknowledged that the reported incident that occurred was abusive in nature which ultimately resulted disciplinary actions.

The licensee failed to ensure resident was protected from abuse.

The severity of this area of non-compliance was minimal harm with potential for actual harm. The scope was determined to be a pattern and there was a compliance history unrelated to this legislation being issued. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

a) The CI report submitted to the MOHLTC, documented that an alleged staff did not follow the interventions documented in the plan of care.

A review of the plan of care for the identified resident stated that the resident had an impairment and outlined interventions related to the specified impairment.

Both identified staff corroborated the events and stated that they observed the alleged staff to not follow the interventions as outlined in the plan of care.

DOC stated that the outcome of the internal investigation concluded that the alleged staff did not follow the interventions or directions as specified in the plan of care. DOC stated that the expectation was for all staff to refer to residents' plan of care for reference in providing individualized care.

The licensee failed to ensure that the care related to approaching resident #040 from the left side as specified in the plan of care was provided by staff.

b) The CI submitted to the MOHLTC documented that an identified resident reported to the nursing staff that they had sustained a fall.

An identified staff stated that they were familiar with resident plan of care and that their role in assisting the resident was to provide set-up assistance only.

A review of the plan of care documented that resident required extensive assistance with activities of daily living.

An identified staff stated that they were aware the plan of care and that the resident was independent with the activities of daily living.

Inspector reviewed this section of the plan with DOC and acknowledged that the care set out in the plan did not reflect their current knowledge and understanding of the resident's care requirements related to activities of daily living as specified in the plan of care.

The licensee failed to ensure that the care related to toileting needs for resident was implemented by staff as specified in the plan.

The severity of this area of non-compliance was minimum harm or potential for actual harm. The scope was determined to be isolated and there was a history of multiple non-compliance issued on November 3, 2016, during a RQI, 2016_448155_0018 as a Voluntary Plan of Correction, issued on June 23, 2016, during a Critical Incident System, 2016_260521_0026 as a Voluntary Plan of Correction, on May 12, 2015, during a RQI 2015_325568_0015 as a Written Notification, issued on September 23, 2014 during a RQI 2014_271532_0032 as a Voluntary Plan of Correction. [s. 6. (7)]

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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive, behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

Minimum Data Set (MDS), under mood and behavior patterns indicated that the identified resident had responsive behaviours.

An identified staff verified that the identified resident had responsive behaviours and indicated that there was nothing documented under behaviours in the kardex for this resident.

An identified staff acknowledged that the resident had responsive behaviour and checked the plan of care and agreed that there was no plan of care under behaviours for this resident.

Plan of care was reviewed and noted that the plan of care was not based on the interdisciplinary assessment of the resident that included mood and behaviour patterns, including wandering, any identified responsive, behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

The severity of this area of non-compliance was minimal harm with potential for actual harm. The scope was determined to be a pattern and there was a compliance history unrelated to this legislation being issued. [s. 26. (3) 5.]

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 responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering, any identified responsive, behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In an interview Residents' Council Representative said that they were not sure if the concerns or recommendations raised at the Residents' Council meeting were responded to within 10 days. Representative further said that the responses to the concerns were always brought to the meeting and discussed.

The Resident Council meeting minutes were reviewed for an identified period of time and concerns were noted in the minutes and the response to the concerns were made at the next Residents’ Council Meetings and not within 10 days.

In an interview the Assistant to the Resident's Council acknowledged that the responses to the council concerns were not made within 10 days of receiving Residents' Council concern or advice, and the managers can be late in responding.

The severity of this area of non-compliance was minimal harm. The scope was determined to be a pattern. There was a compliance history unrelated to this legislation being issued. [s. 57. (2)]

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 licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services, the licensee has failed to ensure that, there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observations during Stage One of the Resident Quality Inspection (RQI), stated that 60 percent of the rooms that were observed had some type of painting or surface area deficiency.

Interior Finishes and Surface Protection Program Policy, stated that an audit will be conducted every four months throughout the home to determine painting and surface protection deficiency. This included but was not limited to resident common and administrative areas, painting touch ups, corner guards, and wall protection replacement and door frame condition. An action plan will be developed based on deficiencies and configuration of home.

Building Service Manager (BSM) indicated that they completed their audits more often than quarterly. They shared that they have routine or scheduled painting focused around the audits. BSM said that when residents were discharged or deceased the rooms were fully painted and interior finishes were corrected, however, if the residents were living in the home over an extended period of time i.e. over 10 years then the only deficiencies picked up through the audits would be corrected, but the rooms would not be fully painted until the resident was discharged from the home. BSM reviewed the audits with Inspector #532. January 2017, audit showed that 96% of the residents' rooms on second and third floor were in compliance with interior deficiencies i.e. painting, corner guards, wall protection, door frame etc. There were few audits completed in the month of March. No audits were done in June. July audits were being conducted during the RQI inspection and were not fully completed.

Review of the audits conducted January 24, 2017, showed that in an identified room

paint touch up was required. However, the work was not completed until 24 days after the concern was identified through the audit. BSM shared that it took some time for the staff to do this. Another audit done January 24, 2017, identified that an identified room's privacy curtain needed hooks, the work was not completed till 13 days after.

BSM was asked about the discrepancy between the audits that were done by the Inspectors during the RQI and the audits completed by the BSM that overlooked these defects. BSM acknowledged that the rooms were needing painting, corner guards, wall protection replacement and door frames touched up. The BSM agreed and stated that the schedules and procedures should be in place for routine and preventive maintenance.

The severity of this area of non-compliance was minimal harm. The scope was determined to be a pattern. There was a compliance history of this legislation being issued on May 12, 2015, in a RQI 2015_325568_0015, as a Voluntary Plan of Correction. [s. 90. (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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

Prevention of Abuse and Neglect of a Resident policy stated that "the ED/Administrator or designate at the time of immediate notification by staff, will immediately notify the Police of any alleged, suspected or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence."

DOC acknowledged the incident that occurred involving an identified resident was considered to be abusive in nature. DOC stated that they were aware that the identified resident became frightened as a result of the incident and the seriousness of this incident resulted in discipline of the alleged staff.

DOC acknowledged that the reported incident regarding staff to resident abuse was not reported to the police.

The licensee failed to ensure that the police force was immediately notified of a witnessed incident of physical abuse towards a resident that may have constituted a criminal offence.

The severity was determined to be a level one as there was minimal harm. The scope of this issue was pattern during the course of this inspection. There was compliance history related to this legislation being issued in the home on September 23, 2014 #2014_271532_0032. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licenses suspects may constitute a criminal offence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

Plan of care for an identified resident stated that they required total assistance for their activities of daily living.

Observations made during both Stage one and Stage two of the Resident Quality Inspection (RQI) noted that on two different specified dates, the identified resident was not dressed appropriately and their body part was exposed.

The Director of Care (DOC) was accompanied to the identified resident and they agreed and stated that they were not dressed appropriately.

At another specified time it was noted again that the resident body part was exposed, resident was sitting in the dining room with other residents at their table and dining room was full.

An identified staff acknowledged that it was a universal responsibility for all staff to ensure that the residents' clothes were adjusted and that the resident was dressed in a dignified manner and consistent with their needs.

The severity was determined to be a level one as there was minimum harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 12, 2015 in a RQI 2015_325568_0015 as a Voluntary Plan of Correction (VPC). [s. 3. (1) 4.]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), APRIL TOLENTINO (218), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2017_601532_0008
Log No. / No de registre :	013365-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 8, 2017
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF GREY 959 9th Avenue East, OWEN SOUND, ON, N4K-3E3
LTC Home / Foyer de SLD :	ROCKWOOD TERRACE HOME FOR THE AGED 575 SADDLER STREET EAST, P. O. BOX660, DURHAM, ON, N0G-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN KRAUS

To CORPORATION OF THE COUNTY OF GREY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee shall ensure that residents #073, #074, #040 and all other residents in the home are provided with treatment, care, services and assistance as per plan of care.

The licensee shall ensure that all direct care staff are trained and kept aware of the contents of the plan of care for resident #073 and #074 and all other residents.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

a) The Critical incident report submitted to the MOHLTC documented that two identified residents fell and were both assisted by staff. The alleged staff member was notified of both incidences but neglected to complete an appropriate post-fall assessments and report the incidences to the oncoming nursing staff member.

A record review of the LTCH's policy titled "Falls Prevention", documented that when a fall occurred, all staff will "ensure the resident is not moved prior to the completion of a preliminary assessment".

In an interview DOC stated that the identified staff involved in the incidences should have waited for a nurse to complete an assessment prior to moving the

identified residents.

The "Falls Prevention" policy also documented that the registered staff was responsible for completing an electronic post-falls assessment when a fall occurred. There was no documentation or post-fall assessments completed for the falls incidences involving the identified residents.

In an interview an identified registered staff stated that they completed the post-fall assessments upon becoming aware of the falls incidences.

A review of these post-fall assessments indicated that there was an injury for one of the identified resident involved in the fall.

An identified registered staff stated that the expectation was to immediately assess the resident for every incident in which a resident falls.

Subsequently, a CI report submitted to the MOHLTC documented that an identified resident was left to wait alone for an extended period of time until assistance was provided.

A record review of the resident plan of care documented interventions related to the identified residents' risk for falls.

A review of a specified report demonstrated that the resident was left unattended for an extended period of time until assistance became available. DOC acknowledged that this incident placed the resident at risk for harm and that it was unacceptable and neglectful practice by staff.

The licensee failed to provide residents with treatment, care, services and assistance related to falls as evidenced by the pattern of inaction that jeopardized the safety of the residents. (218)

2. b) The Critical Incident (CI) submitted to the Ministry of Health and Long-Term Care (MOHLTC), documented an incident of abuse. The incident was witnessed by two additional staff members who were interviewed and corroborated the story.

A review of the plan of care for the identified resident stated that the resident had an impairment and listed the interventions for staff to follow related to the

specified impairment.

A progress note stated that the resident expressed feelings of fear immediately following the incident.

Both staff members that were present during the event verified the incident.

An identified staff stated that they received report from the two witnesses involved and considered the situation to be abusive in nature.

DOC stated that the outcome of the internal investigation demonstrated that the witnesses' statements aligned with one another. DOC acknowledged that the reported incident that occurred was abusive in nature which ultimately resulted disciplinary actions.

The licensee failed to ensure resident was protected from abuse.

The severity of this area of non-compliance was minimal harm with potential for actual harm. The scope was determined to be a pattern and there was a compliance history unrelated to this legislation being issued. [s. 19. (1)] (218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 8th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Nuzhat Uddin

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