Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 2, 2016 | 2016_377502_0006 | 007501-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

SHEPHERD VILLAGE INC.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

SHEPHERD LODGE
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

JULIENNE NGONLOGA (502), JOANNE ZAHUR (589), STELLA NG (507), THERESA BERDOE-YOUNG (596)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): March 16, 17, 18, 21, 22, 24, 29, 30, 31, April 1, 4, 5, 6, 7, and 8, 2016.**

**The following complaint intakes were inspected concurrently with the resident quality inspection: #000439-14 related to missing resident, #014544-15 and #026416 -15 related to maintenance (elevator, air conditioning), #018994-15 related to insufficient staffing and care not provided as per residents' care plan, #022294-15 related to insufficient staffing and continence care #023198-15 related to resident care, #025322-15 related to cockroach infestation, #030870-15 related to staff to resident financial abuse, #003031-16 related to housekeeping (home unsanitary).**

**The following critical incident report intakes were concurrently inspected with the resident quality inspection: #007307-14, #013049-15, #011987-15, and #016990-15, related to fall resulting in injury, #010500-15 related to staff to resident physical abuse, #011953-15, related to resident to resident physical abuse and responsive behaviours,**
**#017870-15, related to maintenance (home's wheelchair), #004786-16 related to resident to resident sexual abuse.**

**During the course of the inspection, the inspector(s) spoke with Vice President (VP) of Client Services, Director of Nursing (DON), Resident Assessment Instrument Coordinator (RAI), Physician, Nurse Managers (NMs), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Director of Food and Nutrition Services (DFN), Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aides (DA), Cooks, Manager of Recreation and Volunteer (MRV), Physiotherapist, Director of Facilities (DF), Facility Coordinator (FC), Housekeeping Aide, Laundry Aide, Administrative Assistant, Accounting Clerk, Manager Quality and Resident Support, Director of Sales & Operation Shopper Home Healthcare, Motion Specialities Representative, residents, Substitute Decision Makers (SDMs) and family members of residents.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**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**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #016 was protected from physical abuse by resident #015.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

1) Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment with a specified date for resident #015 revealed the resident exhibited identified responsive behaviours. Review of the progress notes for resident #015 for a specified period of time, revealed the resident exhibited identified responsive behaviours.

Review of the Dementia Observation System (DOS) records revealed resident #015 was placed on DOS monitoring for his/her responsive behaviours for a specified period of time. Further record review revealed the DOS monitoring had not been completed after this period of time.

Interview with staff #124 confirmed the above intervention and the he/she was unable to provide reasons for not maintaining DOS monitoring for resident #015 after the specified date, despite the persistence of responsive behaviours.

Review of an identified Critical Incident System Report (CIS) and the progress notes for resident #015 revealed that on a specified date and time, resident #015 was wandering along the hallway, and pushed his/her walker several times towards the table in front of the nursing station. The resident was given an identified medication with no effect. Review of the above mentioned CIS, progress notes for resident #015 and interview with resident #016 revealed that on the same day around 1000 hours, resident #015 entered resident #016's room and exhibited responsive behaviour toward resident #016's with an identified mobility device. Resident #016 was sleeping in his/her recliner at the time of the incident and he/she sustained an identified injury.

Interviews with staff #134 and #124 confirmed that despite the known responsive behaviours of resident #015, resident #015 was not being monitored for his/her responsive behaviours or his/her whereabouts after a specified date. Therefore, resident #016 was not protected from physical abuse from resident #015.

2) Review of resident #015's RAI-MDS assessment with a specified date revealed the resident exhibited responsive behaviours. Review of the progress notes for resident #015 for a specified period of time revealed the resident had exhibited identified responsive behaviours.

Review of the progress notes and Mental Health Psychogeriatric Outreach Program (POP) notes for resident #015 revealed on a specified date, during the BSO rounds, resident #015 was referred again to the POP team following a recent escalation in the identified behaviours directed towards to co-residents and family members.

Review of an identified CIS, progress notes for resident #015 and interview with resident #016 revealed on a specified date and time, resident #015 entered resident #016's room and exhibited an identified responsive behaviour toward resident #016, who sustained an identified injury.

Interviews with staff #134 and #124 confirmed interventions were not implemented to monitor resident #015's increased behaviours despite being discussed during the rounds on the same months. Therefore, resident #016 was not protected from physical abuse from resident #015. [s. 19.]

2. The licensee has failed to ensure that resident #002 was protected from emotional abuse by staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident.

Review of the following records: an identified CIS, the home's investigation report, and interviews with staff #120, #108, and #159 revealed that on specified date and time , resident #002 was found soiled in bed with feces, the bed and linens were also soiled. . Resident #002 refused care by the staff. The resident became aggressive during the first attempt at care provided by two staff. A total of five staff, including staff #108 and #120, provided peri-care to prevent injury. Once peri-care was completed resident #002 was positioned at the edge of the bed with his/her legs at the side of the bed. Staff #120 bent down to pull up resident #002's undergarments at which time resident #002 grabbed and pulled staff #120's hair. Staff in the room had to pry resident #002's hand from staff #120's hair.Staff #120 then got up and placed his/her hand on resident #002's head and said, "how would you like it if I pulled your hair?" Resident #002 apologized to staff #120 for his/her action.

Interview with staff #108 revealed that he/she decided extra staff were required in providing care to resident #002 due to the resident's history of aggressive behaviours

towards staff during care and to ensure the safety of resident and staff on May 20, 2015. Two staff held each of the resident's hand and talked to the resident while the other staff provided peri-care. Staff #108 furthered revealed that staff #120 was witnessed putting his/her hand on resident #002's head and said, "how would you like it if I pulled your hair?". Staff #108 told staff #120 not to do that again and the incident was reported to the management.

Interviewed with staff #120 revealed that on specified date, resident #002 pulled his/her hair while he/she bent down to pull up the resident's undergarment. PSW #120 further revealed when his/her hair was free from resident #002's grip, he/she put the hand on the resident's forehead and said, "how would you like it if I pulled your hair?"

Interview with staff #159 confirmed that the above mentioned action taken by staff #120 towards resident #002 was a threat to the resident, and it constituted emotional abuse to the resident. [s. 19. (1)]

3. The licensee has failed to ensure that residents #018 and #019 were protected from sexual abuse from resident #017.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of the RAI-MDS assessment with a specified date, for resident #017 revealed the resident had responsive behaviours. Review of the plan of care with a specified date, for resident #016 revealed the resident had a history of exhibiting an identified responsive behaviour toward particular residents. Review of the progress notes for resident #016 revealed that on a specified date, the resident was seen exhibiting the identified responsive behaviour toward an identified resident. The resident appeared very uncomfortable and resident #017 was referred to a specialist for his/her identified responsive behaviour.

1) Review of the CIS, progress notes for resident #017 revealed that on a specified date, resident #017 was found in resident #018's room exhibiting an identified responsive behaviour.

Interviews with staff #137 and  #154 revealed that on a specified date and time, resident

#017's family member arrived at the unit and was not able to locate the resident. Staff #137 found resident #017 in resident #018's room, exhibiting an identified responsive behaviour. Staff #137 further revealed resident #018 appeared in shock and traumatized. Staff #137 also indicated that resident #018 was able to ring the call bell when he/she needed assistance. However, resident #018 did not ring the call bell at the time of the incident despite the call bell was within reach.

Review of the RAI-MDS assessment with specified date for resident #018 revealed the resident's cognitive skills for daily decision making was moderately impaired. Interviews with staff #137 and #154 revealed the resident was not able to refuse or consent to resident #017's touching of a sexual nature.

Interview with resident #017 revealed the resident denied exhibiting responsive behaviour toward resident #018.

Interview with DON #159 confirmed resident #017's action to resident #018 was sexual abuse because resident #018 was not able to refuse or consent to the touching. In addition, there were no interventions implemented for resident #017's known inappropriate behaviours of inappropriately touching residents. Therefore, resident #018 was not protected from sexual abuse from resident #017.

2) Review of the progress notes of resident #017 and interview with staff #167 revealed on February 24, 2016, at approximately 0845 hours, staff #167 went to the South side from the North side to get linens. When staff #167 walked past the dining room, he/she saw resident #017standing behind resident #019, and his/her hand was inside resident #019's clothing. Resident #019 was sitting at the dining table drinking a beverage. Staff #167 walked around the dining table and faced residents #017 and #019, he/she told resident #017 not to do that. Resident #017 withdrew his/her hand from under resident #017's clothing. Resident #019 did not appear in stress at the time.

Review of the RAI-MDS assessment with a specified date, for resident #019 revealed the resident's cognitive skills for daily decision making was moderately impaired. Interview with staff #154 revealed the resident was not able to refuse or consent to resident #017's responsive behaviours.

Interview with resident #017 revealed that he/she denied exhibiting the identified responsive behaviour toward resident #019.

Interview with the staff #159 confirmed that resident #017's action to resident #019 was sexual abuse because resident #018 was not able to refuse or consent to the behaviour. In addition, there were no interventions implemented for resident #017's known inappropriate behaviours toward residents. Therefore, resident #019 was not protected from sexual abuse from resident #017. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the rights of resident #010 to be treated with courtesy and respect were fully respected and promoted.

During stage one resident #010 indicated he/she had been receiving an identified food item at a specified meal and three weeks prior to the start of this inspection the identified food item was not available at the meal.

Interview with staff #125 revealed that on a specified date, the identified food item was not ready for consumption. Staff #125 further revealed that he/she informed resident #010 and to ask the food item at the next meal.

Interview with resident #010 revealed that he/she saw the identified food items on a cart at the next meal on the same day and asked staff #158 for them. Resident #010 further revealed staff #158 would not allow him/her to explain why he/she wanted the food item. Resident #010 revealed staff #158 was speaking loudly at him/her.

Interview with staff #158 revealed he/she recalled resident #010 requesting an identified food item for him/herself and a co-resident during an identified meal. Staff #158 further revealed he/she did not give the identified foods item to the resident as they where labeled for other resident's snack. Staff #158 denied speaking loudly to resident #010.

Review of the home's internal investigation notes with a specified date revealed on an identified date, staff #158 was loud and not courteous to resident #010 in the dining room when asked for the identified food item for him/herself and spouse.

Review of an identified floor's diet list revealed and interview with staff #133 confirmed resident #010 had been receiving the identified food item at the specified meal every day.

Interview with staff #183 confirmed that staff#158's approach was not acceptable and that resident #010's right to be treated with courtesy and respect was not fully recognized. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident is to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

- On specified date and time, the inspector observed a medication cart left unattended on identified floor lounge area with the electronic medication administration (e-MAR) screen open to resident #001’s medication profile.

Staff #101 was observed in the lounge area and did not have the medication cart within his/her line of sight. Staff #101 was administering medication to resident #101 and had his/her back to the medication cart. While the inspector was in the hallway a visitor walked past the medication cart that had the e-MAR screen open to resident #001’s medication profile.

Interview with staff #101 revealed that he/she had neglected to lock the e-MAR screen when leaving the medication cart unattended.

- On a specified date, the inspector observed a medication cart left unattended on a specified floor hallway with the e-MAR open to resident #030's medication profile.

Staff #142 was observed in room #702 administering medication to resident #030 and did not have the medication cart within his/her line of sight.

While the inspector was in the hallway two visitors walked past the medication cart that had the e-MAR screen open to resident #030's medication profile.

Interview with staff #142 revealed that he/she had neglected to lock the e-MAR screen when leaving the medication cart unattended, and it was the home’s expectation that when the medication cart was left unattended the e-MAR screen should be locked.

Interview with staff #159 confirmed that staff #142 and staff #101 did not protect resident’s personal health information (PHI) by leaving the medication carts unattended with the e-MAR screens unlocked. [s. 3. (1) 11. iv.]

***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 rights of residents to be treated with courtesy and respect were fully respected and promoted, and every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so

that their assessments are integrated, consistent with and complement each other.

Review of the physician order for resident #003 with a specified date, revealed the resident had an identified dietary restriction related to a medical condition.

Interviews with the staff #181 and staff #108 revealed resident #003's medical condition had improved and based on their assessment, resident #003 did not require further dietary restriction. They confirmed their assessment had not been shared with the physician so that he/she discontinue the dietary restriction order. Interview with the staff #155 confirmed there had been no collaboration between the physician, nursing staff and the dietitian. [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident, collaborate with each other in the development and implementation of the plan of care so that the different aspects of care was integrated and was not consistent with and complemented each other.

On identified date and time, the inspector observed resident #003 in the dining room eating independently, total assistance with the meal was not being provided, and he/she left the table early before the end of her meal.

Review of resident #003's most recent plan of care revealed resident required total feeding by staff member along with encouragement and enough time to eat related to the resident pocketing food, requiring several reminders to swallow, and also to ensure the resident eats more than 75 per cent of the meal.

Interview with staff #172 revealed resident #003 required assistance upon his/her return from hospital eight months prior to this inspection. He/she confirmed resident #003's condition had improved and he/she was able to eat independently. Interview with staff #108 revealed the resident was able to eat independently and confirmed the information was not shared with the dietitian.

Interview with staff #181 revealed he/she had not received a referral to reassess the resident's ability to eat independently, and confirmed there was no collaboration between nursing and dietary. [s. 6. (4) (b)]

3. 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.

Review of resident #003's most recent plan of care revealed he/she had an identified dietary restriction.

Review of an identified document revealed resident #003's intake was contrary to the dietary restriction for an identified period of time.

Interviews with staff #108, staff #155 and staff #181 confirmed resident #003's intake was contrary to the dietary restriction. Staff #181 confirmed that care was not provided as per plan. [s. 6. (7)]

4. Interview with resident #005 confirmed that he/she had not received his/her bath/shower on a specified date and often he/she received one bath/shower a week.

Review of an identified floor Bath List with a specified date, revealed residents #005, #039, #040, and #041 were scheduled to receive a bath/shower on a specified date during the day shift.

Review of the direct care staff documentation revealed the above residents had not received their scheduled bath/showers on a specified date. Review of an identified floor's Nursing Schedule for the specified period of time, revealed the resident home area was short staffed by one staff.

Interview with staff #123 and staff #185 confirmed the above resident had not received their bath/shower as per plan. Interview with staff #148 confirmed he/she had not assigned the missing baths/showers to the oncoming shift. [s. 6. (7)]

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

Review of the MDS assessment with a specified date for resident #024 revealed the resident required extensive assistance and two or more persons physical assist for transfer.

Review of the progress notes for resident #024 and interview with the staff #156 revealed the resident was at risk of falls and the current recommendations based on the PT assessment completed on a specified date, included two persons side by side assistance

for transfer, bed and chair alarms, floor mats on both sides of the bed, bed to be kept at the lowest position, and staff to ensure brakes are engaged after lowering the bed.

Review of the care plan for resident #024 with a specified date, revealed the resident required one person pivot transfer related to unsteady gait. Chair and bed alarms, floor mats and bed at the lowest position were not included in the resident's care plan.

During the course of the inspection, the inspector observed the resident having the chair alarm when in chair, bed alarm when in bed, the bed was at the lowest position and floor mats were on both sides of the bed.

Interview with staff #156 revealed that she documented her assessment and recommended interventions in the progress notes, and the nursing staff would update the care plan accordingly. Interview with staff #182 revealed that resident #024 required two people side by side transfer. Interview with staff #171 revealed that resident #024 was at risk of falls and his/her care needs had changed since had changed since an identified injury. Staff #171 further revealed that the process of updating the care plans includes reviewing the progress notes for the last three months and obtaining information from direct care staff.

Interview with staff #171 confirmed that resident #024's care plan was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

6. Review of resident #003's most recent plan of care revealed he/she had a dietary restriction since a specified date, related to a medical condition.

Review of the intake for a specified month, revealed resident #003's intake was contrary to the dietary restriction.

Interview with staff #108 revealed resident #003 condition had improved and had not required a further dietary restriction.
Interview with staff #181 indicated resident #003's restriction should be discontinued. He/she confirmed the plan of care had not been reviewed and revised to reflect the resident's improved medical condition. [s. 6. (10) (b)]

7. Review of an identified CIS, revealed that on a specified date, indicated resident #031 experienced two falls which resulted in a change in his/her care needs. The CIS revealed the following fall prevention interventions were put in place:

- ensure resident wears hip protectors at all times,
- bed alarm to monitor for self-transfers,
- requires two person assistance for lying to sitting and sitting to standing and,
- recommend to place near nursing station when restless for close supervision.

Review of the written plan of care effective May 1, 2015, under the safety focus revealed resident #031 was at high risk for falls and the above mentioned interventions were not included in the plan of care.

Interview with staff #180 revealed that registered staff are to update plans of care when resident's care needs change, and that resident #031's written plan of care had not been reviewed and revised when resident #031's care needs had changed.

Interview with the staff #159 confirmed that the above mentioned expectations had not been followed. [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:***
***- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other,***
***- staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and was consistent with and complemented each other,***
***- the care set out in the plan of care was provided to the resident as specified in the plan, and***
***- the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators**

**Specifically failed to comply with the following:**

**s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any elevators in the home were equipped to restrict resident access to areas that are not to be accessed by residents.

On a specified date and time resident #014 was observed walking in the basement hallway. The Dishwashing Room across from the elevator was opened and unattended, chemical was visible and accessible to anyone. The door leading to the stairway was not locked or secured. Staff were not present in the basement hallway. Observation of the elevators on the same day revealed an access code was available to enter the elevators, but there was no restriction to access the basement when inside the elevators.

Interview with resident #014 revealed he/she was looking for the Director of Facilities and it was not the first time he/she had accessed the basement.

Interview with staff #147 revealed residents who are cognitively alert and who are able to remember the elevator access code are allowed to use the elevators independently.

Interview with staff #159 confirmed the elevators were not equipped to restrict resident access to the basement. [s. 10. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any elevators in the home were equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration**

**Specifically failed to comply with the following:**

**s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was provided with foods that were safe.

On a specified date and time the inspector observed resident #003 in the dining room. The resident was eating a regular textured Tuna Salad Sandwich with crust.

Review of the resident's plan of care and the diet list in the dining room revealed the resident's diet was modified texture diet related to identified medical condition.

Interview with staff #172 revealed he/she was aware of the resident's requirement to have modified texture meal. He/she confirmed that resident #003 was served regular texture sandwich as per resident request, which was not safe for resident #003 to swallow.

Interview with staff #181 confirmed that serving resident #003 a regular textured sandwich put the resident at risk of choking and was not safe. [s. 11. (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 resident was provided with foods that were safe, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On two occasions, the inspector observed a dirty floor with visible food debris and small pieces of paper in a resident sitting area on an identified floor.

Interview with staff #111 revealed that he/she was responsible for sweeping and mopping this area, and did not remember when was the last time that he/she cleaned it, as he/she was focusing on cleaning nearby residents' rooms. Staff #111 immediately proceeded to sweep and mop the area.

Interview with staff #114 indicated the housekeepers and handymen have shared responsibility to ensure that the corridors and common areas on the units are kept clean daily, and confirm the area was not clean and sanitary. [s. 15. (2) (a)]

2. On a specified date, during the initial tour the inspector observed several brown stains on an identified spa room floor. The same stains were observed again six day later.

Interview with housekeeper #111 revealed he/she had already cleaned the spa room earlier, tried to scrub and mop the stains and they didn't come off. The housekeeper reported that the handyman who regularly cleaned the spa room once a week should have been able to remove the stains.

Observation of the identified spa room floor with staff #114 revealed that they had tried neutralizer and floor cleaner and the brown stains would not come off.

When the inspector observed the identified spa room floor two days after, some of the brown stains were removed while others appeared faded. Interview with staff #111 revealed that he/she had tried to remove the stains with a scraper, and removal of the stains should have been addressed by the handyman long before now. [s. 15. (2) (a)]

3. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a good state of repair.

During the initial tour on a specified date, the inspector observed large holes in the walls in spa rooms on identified floors.

Review of maintenance request books revealed no requests for repair of the walls in the spa rooms.
Interview with staff #114 revealed he/she was unaware of holes in the walls in the spa rooms; however the home's expectation was that staff should have reported them to be repaired. Staff #114 confirmed that there was no written schedule for remedial maintenance for the spa rooms, and the home's painter was responsible for painting and patching.

Interview with staff #128 and #129 revealed that the hole in the wall in the fourth floor north spa room had been there approximately one month and the housekeepers and handymen go into all spa rooms frequently to clean and buff the floors.

Staff #114 reported that the  above mentioned holes in the spa room walls had been patched, with plans to paint the patched areas immediately. [s. 15. (2) (c)]

***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, furnishings and equipment were kept clean, sanitary, and were maintained in a good state of repair, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when Registered Practical Nurses and Personal Support Workers cannot come to work.

On specified dates the Ministry of Health and Long-Term Care ActionLine received two complaints. The complainants voiced concerns related to staff shortages and the impact on resident care at the home.

A review of the home's staffing plan did not indicate a back-up plan for when Registered Practical Nurses and Personal Support Workers where unable to come to work.

Interview with staff #159 confirmed the plan did not include a back-up plan for all nursing staff. [s. 31. (3)]

***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 ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when Registered Practical Nurses and Personal Support Workers cannot come to work, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #026.

Review of resident #026's most recent written plan of care revealed the resident was totally dependent for all activities of daily living (ADLs) including transfers and bed mobility. Transfers were completed using a ceiling lift with two staff assistance. Resident #026 had an intervention in place as a comfort measure related to an identified medical condition. Both side rails are to be engaged when resident #026 in bed to prevent slipping off the bed.

Review of an identified CIS, revealed that resident #026 slid off the bed while care was being provided by staff #109 sustaining an identified injury which required a transfer to hospital.

Interview with staff #109 revealed that he/she had resident #026 positioned on his/her left side with the bed rail down while providing care. Staff # 109 turned to the bedside table located to the right of the bed to rinse out the wash cloth when resident #026 began to slide off the bed. Staff #109 attempted to catch the resident but he/she was wearing gloves that were wet and as a result was unable to hold onto resident #026. Staff #109 revealed resident #026 hit his/her head on the floor and sustain injury.

Interview with staff #159 revealed resident #026 at increased risk for falls, both bed rails should have been engaged during care. Staff #159 confirmed that staff #109 used unsafe positioning techniques. [s. 36.]

***Additional Required Actions:***

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

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident had fallen, the resident was to be assessed and that where the condition of circumstances of the resident required, a post – fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On a specified date resident #026 slipped off the bed while care was being provided with one bed rail down. Staff #109 attempted to catch the resident and was unable to. Resident struck his/her head on the floor sustaining an identified injury that required a transfer to hospital.

Review of resident #026's most recent written care plan revealed the resident was totally dependent on staff for all activities of daily living including transfers and bed mobility and for safety, both bed rails should be engaged when the resident was in bed to prevent falls.
Review of the resident's clinical health records failed to reveal a post fall assessment had been completed.

Interview with staff #146 coordinator revealed that the home does not have a post falls assessment instrument specifically designed for falls.

Interview with staff #159 confirmed that resident #026's fall required a post fall assessment and was not completed as the home does not have a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

2. Review of CIS, and resident #023's progress notes revealed that resident #023 had an unwitnessed fall on a specified date. The resident was assessed by registered staff to have severe pain and was transferred to hospital for further assessment. Resident returned to the home the next day with an identified injury.

Review of the resident's clinical health records failed to reveal a completed post fall assessment. Interview with staff #173 revealed that the post fall assessment was not completed for resident #023's fall incident that occurred on a specified date.

Interview with staff #159 confirmed that the home does not have a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

3. Review of CISs and progress notes for resident #024 revealed that the resident had a total of five falls during an identified period of time since his/her admission on a specified date. Two of the five falls caused an injury to the resident where the resident was taken to the hospital and which resulted in a significant change in his/her health status.

Review of the resident's clinical health record failed to reveal completed post falls assessments for the above mentioned fall incidents.

Interview with staff #171 revealed that post fall huddle meetings are held after each fall to discuss the fall incident, and the registered staff would document the incident on the incident report and in the progress notes. Staff #171 confirmed that no post fall assessment template was used for the post falls assessment.

Interview with the staff #159 confirmed that the home does not have a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

4. Record review of an identified CIS revealed that on a specified date, resident #031 had a fall that resulted in a transfer to hospital. Record review of the risk for falls questionnaire revealed resident #031 was at risk for falls.

Record review of progress notes revealed that resident #031 sustained falls specified dates. After the first fall resident #031 exhibited limping and pain to right leg when ambulating. Two days later, resident #031 sustained the second fall and now was using a wheelchair for locomotion. Record review of x-ray results revealed an identified injury.

Interview with staff #180 revealed he/she had not completed a post falls assessment on a clinically appropriate assessment instrument on a specified date.

Interview with the staff #159 confirmed that the home does not have a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (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 when a resident had fallen, the resident was assessed and that where the condition of circumstances of the resident required, a post – fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of an identified CIS submitted on a specified date, and the RAI-MDS assessment with a specified date, for resident #017 revealed the resident had an identified responsive behaviours. Review of the plan of care with a specified date, for resident #017 revealed a focus related to behaviour, in particular the above identified behaviour. The resident was to continue to be free from the identified responsive behaviour by a specified date. Review of current plan of care for resident #017 did not reveal interventions for his/her responsive behaviours.

Interviews with staff #154 and staff #159 confirmed that interventions for resident #017's responsive behaviours should have been developed and included in his/her plan of care. [s. 55. (a)]

***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 ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident's height was measured and recorded annually.

During stage one, resident record review revealed the following residents did not have an annual height measurement done:

- resident #003: February, 2009,
- resident #004: November, 2013,
- resident #006: January, 2009,
- resident #034: May, 2012,
- resident #035: March, 2011,
- resident #042: November, 2012,
- resident #043: April, 2014,
- resident #044: April, 2008,
- resident #045: September, 2013.

Interviews conducted with staff #108, staff #180, and staff #181 confirmed that heights were not taken annually for each resident above as per legislation. [s. 68. (2) (e) (ii)]

***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 was a weight monitoring system to measure and record each resident's height annually, to be implemented voluntarily.***

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**WN #12: 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 ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

1) Review of an identified CIS submitted on a specified date, progress notes for resident #017 and interviews with staff #137 and staff #154 revealed that on a specified date and time, they observed resident #017 touching resident #018 on an identified body part.

Interview with the staff #159 confirmed that the above mentioned allegation of abuse was reported to the Director two days after the occurrence of the incident, not immediately as required under the Act.

2) Review of the progress notes of resident #017 and interview with staff #167 revealed that on an identified date and time, staff #167 went to the South side from the North side to get linens. When staff #167 walked past the dining room, he/she observed resident #017 standing behind resident #019, with his/her hand inside resident #019's clothes.

Review of the Critical Incident System revealed the above mentioned allegation of abuse was not reported to the Director.

Interview with the staff #159 confirmed that the above mentioned allegation of abuse was not reported to the Director. [s. 24. (1)]

2. During stage one resident #005 indicated that staff #116 had taken hold of his/her an identified body part when resident #005 reached for a facecloth on the staff #116's care cart.

Review of resident #005's documentation notes revealed that on an identified date, the resident complained to staff #147 that on the morning of an identified date, he/she was pushed by staff #116. Resident #005 alleged that he/she was reaching for a facecloth on the staff's cart located near the bathroom door and staff #116 said no, taking hold of his/her identified body part pushing him/her back causing resident #005 to fall backwards. Resident #005 alleged there were two other girls in the bathroom as well as his/her roommate.

Interview with staff #116 revealed that he/she was in the bathroom providing care to resident #005's roommate when resident #005 abruptly opened the bathroom door demanding to use the bathroom. Staff #116 further revealed that resident #005 threw towels, facecloths and the roommates clothing onto the floor.

Review of the home's investigation notes revealed that the home conducted a thorough investigation and were unable to verify the allegations of abuse.

Review of an identified CIS revealed the above mentioned allegation of abuse had not been reported to the Director.

Interview with staff #134 confirmed this incident of alleged abuse had not been immediately reported to the Director as per the legislation. [s. 24. (1)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (2) The licensee shall ensure that,**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone was available to provide the assistance.

On a specified date, the inspector observed staff #149 served soup to resident #036 at a specified time; staff #148 became available to assist the resident with feeding 20 minutes after.

Review of resident #036's plan of care dated for the period for an identified period of time, revealed resident #036 required total assistance with feeding to ensure adequate nutrition was consumed.

2. On the same day the inspector observed staff #149 serve soup to resident #037 at a specified time; staff #148 became available to assist the resident with feeding 25 minutes after.

Review of resident #037's plan of care for a specified period of time revealed that resident #037 requires total feeding related to difficult chewing and swallowing.

Interview with staff #148 and staff #149 confirmed that residents #036 and #037 required total assistance with feeding and soup was served prior a staff being available to assist with feeding.

Interview with the staff #181 confirmed that the home's expectation was to serve resident's meal when a staff is available to assist. [s. 73. (2) (b)]

**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Review of the home's infection control education records for 2015, that included risk of infection and use of personal protective equipment, modes of transmission and how to hand wash revealed three per cent of all staff had not received retraining in infection control and prevention.

Interview with the infection control lead confirmed that three per cent of all staff had not received the annual retraining in infection control and prevention for 2015. Interview with staff #159 confirmed that the above identified staff were active and had not received retraining in infection control and prevention for 2015. [s. 76. (4)]

2. The licensee failed to ensure that all staff received retraining annually to the home's policy to promote zero tolerance of abuse and neglect of residents.

Record review of the home's staff education records for 2015, revealed that five per cent of staff had not received annual retraining in the home's policy to promote zero tolerance of abuse and neglect of residents.

Interview with staff #159 confirmed that five per cent of staff had not received annual retraining in the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Review of the home's "Zero tolerance of abuse and Neglect of Residents", NURS VI - 116, effective date of March 2014, failed to reveal procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Interview with staff #159 confirmed the above mentioned components were not included in the home's policy that promotes zero tolerance of abuse and neglect of residents. [s. 96. (a)]

2. The licensee failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to deal with residents who have been allegedly abused or neglected.

Review of the home's "Zero tolerance of abuse and Neglect of Residents", NURS VI - 116, effective date of March 2014, failed to reveal procedures and interventions to deal with residents who have been allegedly abused, or neglected.

Interview with staff #159 confirmed the above mentioned components were not included in the home's policy that promotes zero tolerance of abuse and neglects of residents [s. 96. (b)]

3. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse and neglect.

Review of the home's "Zero tolerance of abuse and Neglect of Residents", NURS VI - 116, effective date of March 2014, failed to reveal measures and strategies to prevent abuse and neglect.

Interview with staff #159 confirmed the above mentioned components were not included in the home's policy that promotes zero tolerance of abuse and neglects of residents. [s. 96. (c)]

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a response to a verbal complaint made to the licensee or a staff member concerning the care of resident #010 was provided within 10 days of receiving the complaint.

Record review of the home's investigation notes revealed resident #010 made a verbal complaint about staff #158 to staff #183 on an identified date. The complaint involved staff #158 speaking loudly and being discourteous to resident #010 in the dining room when asked for an identified food item for him/herself and a co-resident.

Interview with staff #183 revealed that since this incident occurred on the evening shift the verbal complaint had been forwarded to the evening staff#141 to investigate as well as to the staff #159.

Interview with resident #010 revealed that no one from the home had provided a response to his/her verbal complaint.

An interview with the DON confirmed that staff #141 had conducted an investigation but had not "closed the loop" by providing a response to resident #010, which was 39 days after the complaint [s. 101. (1) 1.]

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**
**3. Actions taken in response to the incident, including,**
**i. what care was given or action taken as a result of the incident, and by whom,**
**ii. whether a physician or registered nurse in the extended class was contacted,**
**iii. what other authorities were contacted about the incident, if any,**
**iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
**v. the outcome or current status of the individual or individuals who were involved in the incident.**
**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that actions taken in response to an incident, including the outcome and current status of resident #026 were amended.

Record review of identified CIS, revealed that resident #026 had a fall from his/her bed on a specified date, and sustained an injury that resulted in a transfer to hospital. The CIS also revealed an amendment was requested by the central intake assessment triage team (CIATT) on a specified date, with the outcome of the home's investigation, whether the fall was witnessed or resident was found on the floor and to update the resident's status upon return from hospital.

Interview with staff #155 revealed that the staff #159 had been receiving amendment requests and would forward to staff #134 to complete.

Interview with staff #134 confirmed that CIS for resident #026 had not been amended. [s. 107. (4) 3. v.]

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

**Specifically failed to comply with the following:**

**s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written record was kept of the results of the annual evaluation of the medication management system and any changes that were implemented.

Record review and interview with staff #159 confirmed that the home had not completed an annual evaluation and did not have a written record of the medication management system evaluation for 2015. [s. 116. (5)]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that was secured and locked.

On a specified date, the inspector observed on an identified floor a medication cart left unattended and unlocked. Staff #101 was administering medication to resident #001 and did not have the medication cart within his/her sight as his/her back was to the medication cart. Observations further revealed many residents within the vicinity and a visitor walked past the unlocked medication cart.

Interview with staff #101 revealed that he/she had neglected to lock the medication cart when leaving unattended. [s. 129. (1) (a)]

2. On a specified date the inspector observed an unlocked medication cart left unattended on an identified floor hallway.

Staff #142 was observed in an identified room administering medication to resident #030 and did not have the medication cart in his/her line of sight.

While inspector was in the hallway two visitors walked past the unlocked medication cart.

Interview with staff #142 revealed he/she had neglected to lock the medication cart when leaving unattended.

Interview with staff #159 confirmed that staff's #142 and #101 had not ensured that drugs in the medication cart were kept secure and locked when the medication cart was left unattended. [s. 129. (1) (a)]

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Interview with resident #006's family member reported a medication administration error that occurred on a specified date, on the day shift, while he/she was visiting. The family member reported that nursing staff would regularly give him/her resident #006's medication to administer at an identified meal time, and gave him/her the wrong medication at a specified date and time. Staff #171 gave the family member an identified medication to administer to resident #006, when it was ordered to be given in the morning. Resident #006's family member then returned the above mentioned medication to the nurse and informed him/her that it was the wrong medication at the wrong time.

Record review of resident #006's physician's quarterly medication review with a specified date, directed registered staff to administer the above identified medication two times daily, and the e-MAR indicated specified time.

Interview with staff #171 revealed that he/she missed administering the above mentioned medication to resident #006 at in the morning on an identified date, so the resident missed one dose.

Interview with staff #130 confirmed that staff #171 made a medication administration error on an identified date, for resident #006, and immediately documented it on the home's Medication Incident /Near Incident Report. Resident #006 had not received the above mentioned medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On a specified date, the inspector observed in a shared bathroom on the seventh floor the following unlabeled personal care items:
-a urinal stored on the back of the toilet and,
-two wash basins.

Interviews with staff #102 and staff #159 confirmed that all personal care items in shared bathrooms are to be labeled. [s. 229. (4)]

2. On a specified date, the inspector observed the following:
- a dirty unlabelled wash basin and kidney basin stored in an identified floor's spa room. Interview with staff #103 revealed that they should have been stored in residents' room, not in the spa room,
- two unlabelled, dirty wash basins stored in a tub in an identified floor south spa room. Interview with staff #104 revealed that they should have been labelled and kept in residents' rooms,
- one unlabelled disposable urine hat with small dead black bugs inside, in an identified floor south spa room. Interview with staff #105 revealed that they are usually discarded after use. The home's practice was that they should have been labelled and stored in residents' rooms,
-dirty unlabelled comb with hair contained in a drawer in an identified floor's spa room. Interview with staff #106 revealed that the comb should have been stored in residents' rooms,
-two unlabelled dirty urine hats stored in the tub, and one dirty unlabelled used comb in an identified floor's spa room. Interview with staff #107 revealed that the urine hat should be labelled, and the comb should have been stored in residents' rooms. [s. 229. (4)]

3. On a specified date, the inspector observed staff #142 take a glucometer with an illegible label on it that was loosely stored in the top drawer of the medication cart and proceeded to obtain a blood glucose test from resident #027. Staff #142 then proceeded to open the bottom drawer of the medication cart where six to seven black glucometer pouches were stored. Further observations revealed two of these black pouches were labeled with resident #027's name.

Review of the home's policy titled "Glucometer", number NURS V-85-1, dated February 2016, revealed that all residents are to have their own glucometers.
Review of Remedy's Rx policy titled "Blood Glucose Meter", number 9.10 dated September 1, 2013, revealed "that in keeping with good infection control practices, each resident should have their own blood glucose meter."

Interview with staff #142 revealed that he/she should have used resident #027's own glucometer. He/she then placed one of the labeled black pouches with resident #027's name in the top drawer of the medication cart.

Interview with staff #159 confirmed that registered staff are required to use residents’ own glucometer for blood glucose testing and that staff #142 did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

4. Review of the home's policy titled "Hand Hygiene", number ICM H-10, with an effective date of February 2016, revealed that all employees are to use the four moments in hand hygiene during their daily practice. Moment number two refers to before any aseptic procedure staff should clean their hands before to protect the resident against harmful organisms including the resident's own organisms, entering his/her body.

On a specified date, the inspector observed staff #142 using a glucometer to obtain a blood glucose testing from resident #027 staff #142 did not wash or sanitize his/her hands before or after the procedure.

Interview with staff #142 revealed he/she should have sanitized his/her hands prior to obtaining the blood glucose testing.

Interview with staff #159 revealed that all staff should use the four moments of hand hygiene during their daily practice and that a blood glucose testing was considered an aseptic technique requiring hand hygiene. Staff #159 confirmed that staff #142 had not participated in the implementation of the infection prevention and control program. [s. 229. (4)]

**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records**
**Every licensee of a long-term care home shall ensure that,**
**(a) a written record is created and maintained for each resident of the home; and**
**(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.**

**Findings/Faits saillants :**

The licensee has failed to ensure that licensee of a long-term care home shall ensure that the resident's written record was kept up to date at all times.

Record review of a complaint with a specific date, regarding suspected financial abuse towards resident #046 revealed the home also submitted a CIS to the MOHLTC.

Record review of resident #046's clinical health record and business file revealed no Power of Attorney (POA) documents.

Interviews with the staff #159, staff #159, staff #170 and staff #134 confirmed that the home had not been able to locate the resident's POA for finances document.

Interview with the resident's POA #183 for finances confirmed that the home had been given a copy of the POA documents previously on more than one occasion, and he/she will provide another copy to the home. [s. 231. (b)]

**Issued on this 17th day of June, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JULIENNE NGONLOGA (502), JOANNE ZAHUR (589), STELLA NG (507), THERESA BERDOE-YOUNG (596) |
| **Inspection No. / No de l'inspection :** | 2016_377502_0006 |
| **Log No. / Registre no:** | 007501-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 2, 2016 |
| **Licensee / Titulaire de permis :** | SHEPHERD VILLAGE INC.<br>3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9 |
| **LTC Home / Foyer de SLD :** | SHEPHERD LODGE<br>3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | BROCK HALL |

To SHEPHERD VILLAGE INC., 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 :** 901

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:

1) Develop and implement a process to monitor and document resident #015's whereabouts,

2) Develop a process to monitor the interventions that been developed for resident #015 to ensure they have been implemented, and

3) Develop and implement interventions for resident #017's sexually abusive behavior to ensure residents are safe from his/her advances.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that resident #016 was protected from physical abuse by resident #015.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

1) Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment with a specified date for resident #015 revealed the resident exhibited identified responsive behaviours. Review of the progress notes for resident #015 for a specified period of time, revealed the resident exhibited identified responsive behaviours.

Review of the Dementia Observation System (DOS) records revealed resident #015 was placed on DOS monitoring for his/her responsive behaviours for a

specified period of time. Further record review revealed the DOS monitoring had not been completed after this period of time.

Interview with staff #124 confirmed the above intervention and the he/she was unable to provide reasons for not maintaining DOS monitoring for resident #015 after the specified date, despite the persistence of responsive behaviours.

Review of an identified Critical Incident System Report (CIS) and the progress notes for resident #015 revealed that on a specified date and time, resident #015 was wandering along the hallway, and pushed his/her walker several times towards the table in front of the nursing station. The resident was given an identified medication with no effect.

Review of the above mentioned CIS, progress notes for resident #015 and interview with resident #016 revealed that on the same day around 1000 hours, resident #015 entered resident #016's room and exhibited responsive behaviour toward resident #016's with an identified mobility device. Resident #016 was sleeping in his/her recliner at the time of the incident and he/she sustained an identified injury.

Interviews with staff #134 and #124 confirmed that despite the known responsive behaviours of resident #015, resident #015 was not being monitored for his/her responsive behaviours or his/her whereabouts after a specified date. Therefore, resident #016 was not protected from physical abuse from resident #015.

2) Review of resident #015's RAI-MDS assessment with a specified date revealed the resident exhibited responsive behaviours. Review of the progress notes for resident #015 for a specified period of time revealed the resident had exhibited identified responsive behaviours.

Review of the progress notes and Mental Health Psychogeriatric Outreach Program (POP) notes for resident #015 revealed on a specified date, during the BSO rounds, resident #015 was referred again to the POP team following a recent escalation in the identified behaviours directed towards to co-residents and family members.

Review of an identified CIS, progress notes for resident #015 and interview with resident #016 revealed on a specified date and time, resident #015 entered

resident #016's room and exhibited an identified responsive behaviour toward resident #016, who sustained an identified injury.

Interviews with staff #134 and #124 confirmed interventions were not implemented to monitor resident #015's increased behaviours despite being discussed during the rounds on the same months. Therefore, resident #016 was not protected from physical abuse from resident #015. [s. 19.] (507)

2. The licensee has failed to ensure that residents #018 and #019 were protected from sexual abuse from resident #017.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of the RAI-MDS assessment with a specified date, for resident #017 revealed the resident had responsive behaviours. Review of the plan of care with a specified date, for resident #016 revealed the resident had a history of exhibiting an identified responsive behaviour toward particular residents. Review of the progress notes for resident #016 revealed that on a specified date, the resident was seen exhibiting the identified responsive behaviour toward an identified resident. The resident appeared very uncomfortable and resident #017 was referred to a specialist for his/her identified responsive behaviour.

1) Review of the CIS, progress notes for resident #017 revealed that on a specified date, resident #017 was found in resident #018's room exhibiting an identified responsive behaviour. Interviews with staff #137 and #154 revealed that on a specified date and time, resident #017's family member arrived at the unit and was not able to locate the resident. Staff #137 found resident #017 in resident #018's room, exhibiting an identified responsive behaviour. Staff #137 further revealed resident #018 appeared in shock and traumatized. Staff #137 also indicated that resident #018 was able to ring the call bell when he/she needed assistance. However, resident #018 did not ring the call bell at the time of the incident despite the call bell was within reach.

Review of the RAI-MDS assessment with specified date for resident #018 revealed the resident's cognitive skills for daily decision making was moderately impaired. Interviews with staff #137 and #154 revealed the resident was not able

to refuse or consent to resident #017's touching of a sexual nature.

Interview with resident #017 revealed the resident denied exhibiting responsive behaviour toward resident #018.
Interview with DON #159 confirmed resident #017's action to resident #018 was sexual abuse because resident #018 was not able to refuse or consent to the touching. In addition, there were no interventions implemented for resident #017's known inappropriate behaviours of inappropriately touching residents. Therefore, resident #018
was not protected from sexual abuse from resident #017.

2) Review of the progress notes of resident #017 and interview with staff #167 revealed on February 24, 2016, at approximately 0845 hours, staff #167 went to the South side from the North side to get linens. When staff #167 walked past the dining room, he/she saw resident #017standing behind resident #019, and his/her hand was inside resident #019's clothing. Resident #019 was sitting at the dining table drinking a beverage. Staff #167 walked around the dining table and faced residents #017 and #019, he/she told resident #017 not to do that. Resident #017 withdrew his/her hand from under resident #017's clothing. Resident #019 did not appear in stress at the time.

Review of the RAI-MDS assessment with a specified date, for resident #019 revealed the resident's cognitive skills for daily decision making was moderately impaired. Interview with staff #154 revealed the resident was not able to refuse or consent to resident #017's responsive behaviours.

Interview with resident #017 revealed that he/she denied exhibiting the identified responsive behaviours toward resident #019.

Interview with staff #159 confirmed that resident #017's action to resident #019 was sexual abuse because resident #018 was not able to refuse or consent to the behaviour. In addition, there were no interventions implemented for resident #017's known inappropriate behaviours toward residents. Therefore, resident #019 was not protected from sexual abuse from resident #017. [s. 19. (1)]

The scope of this finding was a pattern related to three incidents of abuse, one physical and two sexual. The severity showed minimal harm/risk or a potential for actual/harm risk. The Compliance History Report showed previous non-compliances unrelated to this finding. As a result of scope, severity and previous

compliance history a compliance order is warranted. (507)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 2nd day of May, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Julienne NgoNloga

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