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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ Registre no	Type of Inspection / Genre d’inspection
Aug 31, 2017;	2017_587129_0007 (A1)	016419-16, 034944-16, 000624-17, 002569-17, 005832-17, 008800-17, 009016-17	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

Amend compliance dates for three Compliance Orders to October 16, 2017

Issued on this 31 day of August 2017 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Aug 31, 2017;	2017_587129_0007 (A1)	016419-16, 034944-16, 000624-17, 002569-17, 005832-17, 008800-17, 009016-17	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): May 5, 30, 31, June 1, 2, 6, 7, 8, 9, 12, 13, 14, 15, 20, 21, 22, 23 and 30, 2017

During this inspection the following logs were inspected: 009016-17 and 008800-17 related to unexpected death, 005832-17 related to abuse, 002569-17 related to abuse, 000624-17 related to abuse, 034944-16 related to falls and 016419-16 related to falls.

The following inspections were completed concurrently with this Critical Incident Inspection: Complaint Inspection #2017_587129_008 and Follow-up Inspection #2017_587129)006

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Food Service Supervisor (FSS), Environmental Services Manager (ESM), Housekeeping staff, Registered Dietitian (RD), 2 Directors of Care (DOC), Resident Assessment Instrument-Minimum Data Set Coordinator, Education Lead, Quality Improvement Coordinator, Infection Control Lead and the Administrator.

During the course of this inspection the home was toured, resident's clinical records were reviewed, resident care was observed, policy and procedure documents were reviewed, program documents were reviewed, training records were reviewed and other documents maintained by the home were reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Responsive Behaviours

Skin and Wound Care

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

16 WN(s)
9 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

The licensee failed to protect three identified residents from emotional abuse.

In accordance with O. Reg. 79/10, s. 2(1) emotional abuse is defined as “any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviours or remarks understands and appreciates their consequences”.

1. During an interview, a co-resident disclosed that they did not feel safe in the home and had not felt safe in the home for some time. On an identified dated in 2016, documentation in an identified resident's clinical record indicated that the resident engaged in an altercation with the co-resident. A review of the co-resident’s clinical record indicated that there was no documentation of the incident that occurred on the above noted date. During an interview, the co-resident was able to recount the incident and disclosed that they did not feel safe in the home, had not felt safe for some time and their approach was to try to avoid contact with the identified resident.
The co-resident experienced emotional abuse when they described being fearful and feeling unsafe both following an altercation initiated by the identified resident and currently when they identified their strategy was to avoid contact with the identified resident whenever possible. It was confirmed in clinical records and by staff who knew and provide care to the identified resident that the resident understood and appreciated the consequences of their actions.

2. During an interview a co-resident disclosed that they did not feel safe in the home as a result of actions by an identified resident.
Clinical documentation made on an identified date in 2017, indicated that an identified resident engaged in an altercation with the co-resident. During an interview, the co-resident was able to recount the incident as it was described in clinical documentation and during the discussion the resident disclosed that they did not feel safe in the home as a result of the actions of the identified resident. The co-resident indicated that they just try to stay away from the identified resident. The co-resident continued to be fearful of further altercations with the identified resident when they indicated their strategy was to try and stay away from the identified resident. It was confirmed in clinical records and by staff who knew and provide care to the identified resident that the resident understood and appreciated the consequences of their action.

3. A review of clinical notes, made on and identified dated in 2017 by the Registered Nurse working at the time, indicated that an identified resident engaged in an altercation with a co-resident.

The co-residents comments, documented in the clinical record, confirmed that the co-resident experienced emotional abuse when they described to DOC #609 that following the above noted incident, they no longer felt comfortable or safe in the home. It was confirmed in clinical records and by staff who knew and provide care to the identified resident that the resident understood and appreciated the consequences of their action.

The licensee failed to protect three identified co-residents from emotional abuse when:

-The licensee failed to develop or implement strategies to address and manage physically aggressive behaviours demonstrated by an identified resident.
-The licensee failed to reassess an identified resident when their care needs changed and the resident demonstrated an increase in responsive behaviours.
- The licensee failed to develop strategies related to a potential trigger for responsive behaviours demonstrated by an identified resident.
-The licensee failed to take action to minimize the risk of altercations between residents, particularly in areas of the home were altercations between residents had been known to occur.
-The licensee failed to interview two co-residents following incidents where these two residents were involved in altercations with an identified resident in order to determine the two co-residents response to the incidents and to determine if the co-residents required support to deal with their fear of further altercations.
-The licensee failed to complete an annual evaluation for the 2016 calendar year of the of the items required in O. Reg. 79/10, s. 53(1) to meet the needs of residents with responsive behaviours.
-The licensee failed to complete an annual evaluation for the 2016 calendar year of the effectiveness of the licensee’s policy to promote zero tolerance of abuse of residents or to determine what changes and improvements needed to be made. [s. 19. (1)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care as well as resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours.
At the time of this inspection documents provided by the home that were identified as directions for staff related to the management of responsive behaviours included:
- Quality Improvement Program – Nursing/Resident Care Annual Evaluation-Behaviour Management Program and Responsive Behaviour Philosophy- QIP I-05-05, last reviewed January 10, 2017.
- Resident Care and Services Manual – Resident Special Needs – Behavioural Management & Responsive Behaviour Philosophy and Assessment – RCS G-45-05, last revised July 15, 2013.
- Quality Improvement Program – Nursing/Resident Care Audit & Evaluation – Behaviour (Including Responsive Behaviour) Management and Audit and Evaluation – QIP I-10-10, last reviewed on November 8, 2011.

A review of the above noted documents indicated that the documents referred to "triggers for behaviours" but did not provide written approaches for staff to follow in the assessment of responsive behaviours and specifically the process to follow in order to identify possible triggers for responsive behaviours being demonstrated by residents.

Clinical records reviewed for three identified residents confirmed that these residents were identified to demonstrate responsive behaviours and there was no clinical documentation to indicate that an attempt to identify triggers for the specific behaviours being demonstrated by these residents had been completed.

Director of Care (DOC) #609 confirmed that the home did not have or utilize a tool or a process for the identification of possible triggers for responsive behaviours and there were no written approaches for staff to follow. [s. 53. (1) 1.]

2. The licensee failed to ensure that at least annually, the matters referred to in O. Reg. 79/10, s. 53(1) were evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Staff #613 and documents provided by the home confirmed that the home had not completed an evaluation of the written approaches to care, written strategies, monitoring and reporting protocols or protocols for referrals related to the

management of responsive behaviour initiatives in the home for the 2016 calendar year. [s. 53. (3) (b)]

3. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours, where possible.

Staff did not ensure that strategies were developed and implement for each resident demonstrating responsive behaviours.

DOC #609 and clinical documentation confirmed that the home did not have a method for identification of behavioural triggers, however over a 10 month period of time an identified resident's plan of care included completed screening tools that indicated possible triggers for the behaviours being demonstrated by resident. At the time of this inspection directions for care documented for the resident did not include strategies to manage the identified potential triggers or interventions to manage the responsive behaviours being demonstrated by the resident and the resident continued to demonstrate the identified behaviours..

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

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 and ensuring that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to the behaviours, where possible., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

a) An identified resident's clinical record and staff providing care to the resident confirmed that the resident engaged in altercations with co-residents.

i) On an identified dated in 2016, staff documented an altercation between an identified resident and a co-resident. At the time of this inspection the co-resident was able to recall the incident and explain what had happened. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.
ii) On an identified date in 2016, staff documented an altercation between an identified resident and a co-resident. Clinical documentation indicated that following this incident staff offered to relocate the identified resident and the resident refused. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or

implement interventions to prevent a re-occurrence of this or a similar altercation.
iii) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. Documentation in the co-resident’s clinical record indicated that the resident reported the altercation to nursing staff. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a re-occurrence of this or a similar altercation.
iv) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. During an interview with the co-resident they recounted the incident (as was documented in the clinical record) to the inspector. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a re-occurrence of this or a similar altercation.
v) On an identified date in 2017, an identified resident initiated an altercation with a co-resident during which co-resident sustained injuries. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a re-occurrence of this or a similar altercation with other co-residents.
vi) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a re-occurrence of this or a similar altercation.

b) An identified resident’s clinical record and staff providing care to the identified resident confirmed that the resident engaged in altercations with co-residents.

i) Clinical documentation indicated that on an identified date in 2016, the identified resident was involved in an altercation with a co-resident. Clinical documentation made at the time of the altercation indicated the co-resident did not sustain an injury as a result of the altercation.

ii) Clinical documentation indicated that on an identified date in 2017, the identified resident engaged in an altercation with the co-resident. Clinical documentation made at the time of the altercation indicated that the co-resident sustained injuries as a result of the altercation.

DOC #609 and the clinical record confirmed that a referral to an out-of-home consultant was made for the identified resident following the altercation on the

identified date in 2016, but that staff were not provided with any care directions or other strategies to minimize the risk of further altercations either after the first or second altercation.

The licensee did not take steps to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (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 failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

Resident #004's plan of care did not provide clear directions to staff and others who were responsible to provide direct care to the resident when it was identified that documentation including; electronic progress notes and risk management reports, identified fall management strategies that were not communicated to direct care staff.
DOC #609 confirmed that the documents staff used to identify the care requirements of the resident were the Care Plan and the Kardex.
Clinical documentation made by nursing staff and physiotherapy staff in clinical

notes indicated that three strategies were to be used to assist in the management of the risk for falling for the resident. DOC #609 confirmed that it was an expectation that the care strategies identified above would be included in both the Care Plan and the Kardex to ensure that staff providing direct care to the resident were provided with clear direction related to how the risk for falling was to be managed for resident #004.
DOC #609 and clinical documentation confirmed that the above noted strategies were not included in the documents that direct care staff used to provide care to the resident and the resident’s plan of care did not provide clear direction.
[s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in different aspects of the care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of the care are integrated and are consistent with and complement each other.

Nursing staff and physiotherapy staff did not collaborate in the development and implementation of resident #004’s plan of care related to falls prevention and management.

The Physiotherapist completed a referral on an identified date in 2017 following a fall resident #004 experienced. The Physiotherapist indicated in a clinical note that staff were to continue using three identified strategies to manage the risk of falling for the resident. The Physiotherapist, DOC #609 and clinical documentation confirmed that collaboration in the development of the resident’s plan of care had not occurred when strategies identified by the Physiotherapist were not included in documents used by staff to identify the care the resident was to receive.

The Physiotherapist completed a second referral on an identified date in 2017, following a fall the resident had on the same day. The Physiotherapist again documented in a clinical note that staff were to continue the above noted strategies and an additional strategy should be implemented based on the circumstances around the most recent fall.

The Physiotherapist completed a third referral on an identified date in 2017, following a fall the resident had the previous day. The Physiotherapist indicated the resident would benefit from the implementation of the additional strategy identified above. Nursing and the Physiotherapist did not collaborate in the development of resident #004’s plan of care when strategies identified by the Physiotherapist were

not included in the documents used by staff to identify the care the resident was to receive.

The Physiotherapist confirmed that they often speak with nursing staff following their assessments of residents and would expect nursing staff to update the care plan. [s. 6. (4) (b)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

An identified resident's plan of care was not reviewed and revised when their care needs changed in relation to responsive behaviours. Over an 11 month period of time documentation made in the resident's clinical record indicated that the resident demonstrated five types of responsive behaviours.

a) On an identified date in 2016, staff identified that the resident's care need had changed in relation to responsive behaviours when they completed Minimum Data Set (MDS) coding that indicate the resident demonstrated type (1) responsive behaviour one to three days during the observation period that was identified as easily altered, type (2) responsive behaviour one to three days during the observation period that was easily altered, and type (3) responsive behaviour one to three days during the observation period that was easily altered. The preceding MDS coding completed three months earlier, indicated the resident demonstrated type (3) responsive behaviour one to three days during the observation period. Staff who completed MDScoding did not review and revise the resident's plan of care when it was identified the resident's care needs changed and the resident was demonstrating two additional responsive behaviours not previously identified. DOC #608 and DOC #609 as well as clinical documentation confirmed that the resident's plan of care was not reviewed or revised when it was identified that the resident's care needs related to the management of responsive behaviours had changed.

b) On an identified date, staff identified that the resident's care needs had changed when they completed a Responsive Behaviour Risk Screen which indicate the resident's risk related to responsive behaviours had increased over the previous two months from a moderate risk level to a high risk level. DOC #609 and clinical documentation confirmed that following this indication of a rising risk level related to responsive behaviours staff had not reviewed or revised the resident's plan of care in relation to the management of this rising risk level.

c) The resident was reassessed three months later when staff completed a Responsive Behaviour Risk Screen which indicated the resident’s risk related to responsive behaviours remained at a high level. DOC #609 and clinical documentation confirmed that staff had not reviewed or revised the resident’s plan of care in order to manage this ongoing high risk level. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident’s plan of care was reviewed and revised when the care set out in the plan had not been effective.
Staff failed to review and revise resident #016’s plan of care related to falls when the care set out in the plan had not been effective.
Clinical documentation confirmed that staff had identified a care focus related to falls when it was identified resident #016 was at risk for falling. On an identified date in 2015, staff who developed the plan of care related to falls documented that the goal of care was that the resident would be free of falls through the next review date and this remained the goal of care for this resident related to falls.
DOC #608, documents provided by the home and the resident’s clinical record confirmed that resident #016 fell several times over the next four months. During this period of time the resident’s plan of care was not reviewed or revised when care provided to the resident was not effective in achieving the goal of care identified for the resident.
During the above noted period of time a historical review of the resident’s plan of care confirmed that the plan had not been reviewed or revised when there were no new care interventions added to the plan of care related to falls managment.
Resident #016 continued to fall over the next two months and the resident’s plan of care was not reviewed or revised when the care provided to the resident continued to not be effective in attaining the established goal of care.
Documents (Care Plan and Kardex) used by direct care staff to identify the care required by the resident indicated “the resident consistently disabled one of the strategies in place to manage falls. DOC #608 confirmed that it would be the expectation that if a care intervention was not successful the plan of care would be reviewed and revised, resident #016’s plan of care had not been revised and the resident continued to fall. [s. 6. (10) (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 and ensuring compliance with s.6(1)(c), s. 6(4)(b), 6(10)(b) and 6(10)(c), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

In accordance with O. Reg. 79/10, s. 30(1) the interdisciplinary falls prevention and management program identified in O. Reg 79/10, s. 48(1) 1 is to include relevant policies, procedures and protocols.

1. Upon request DOC #608 provided documents that provided directions for staff related to the implementation of the home's Falls Prevention Program. The package of documents was identified as “Falls Prevention Program – Quality Management” and the documents indicated they were last reviewed in March 2014.

a) The above noted documents included a direction that "if there is evidence of a head injury, staff were to initiate the Head Injury Routine (HIR) immediately and follow the HIR protocol". DOC #609 confirmed that if a resident experienced an unwitnessed fall it would be the expectation that staff would initiate HIR.
The Head Injury Routine procedure was identified as "Resident Care and Services Manual", section "Resident Safety", subject "Head Injury Routine", I.D. RCS E-35 with a revised date of April 5, 2017.
The above noted document directed staff to check and record vital signs for 72 hours on the Neurological Flow Sheet – every 15 minutes for one hour, every 30 minutes for one hour, every hour for four hours and every eight hours for seven shifts. The document identified that "vital signs" for HIR include: blood pressure, pulse, respiration, pupil reaction, level of consciousness, movement, hand grasp and verbal response.

i) DOC #608 confirmed that at the time of this inspection they were unable to provide HIR Flow Sheets to confirm that staff had complied with the directions contained in the above noted procedure following unwitnessed falls resident #004 experienced on four identified dates in 2017. HIR Flow Sheet provided confirmed that staff did not comply with the directions contained in the procedure when the HIR Flow Sheet indicated they had not checked the resident's vital signs every hour for four hours and they had not checked the resident's vital signs every eight hours for seven shifts.

ii) DOC #608 confirmed that at the time of this inspection they were unable to provide HIR Flow Sheets to confirm that staff had complied with the directions contained in the above noted procedure following unwitnessed falls resident #016 experienced on three identified dates in 2016. HIR Flow Sheets provided for unwitnessed falls confirmed that staff did not comply with the directions contained in the procedure when the flow sheet indicated they did not check the resident's vital signs every 30 minutes for one hour, every hour for four hours and every eight hours for seven shifts, vital signs every 30 minutes for one hour, every hour for four hours and every eight hours for seven shifts.

iii) DOC #608 confirmed that at the time of this inspection they were unable to provide a HIR Flow Sheet to confirm that staff had complied with the directions contained in the above noted procedure for an unwitnessed fall resident #013 experienced on an identified date in 2017.

b) The above noted documents directed “an assessment of the fall must be done immediately following the fall by a registered staff, it is the responsibility of the registered staff in charge of the resident's care to provide accurate and timely information and to make referrals to appropriate members of the interdisciplinary team and Rehab/Restorative Therapist is notified of falls and will do a post fall assessment as well form a rehab/restorative point of view”.
i) Staff in the home did not comply with the above noted direction when there was no evidence in the clinical record that following fall incidents experienced by resident #004 on two identified dates in 2017, that nursing staff notified the Rehab/Restorative Therapist that the resident had experienced a fall and assessments were not completed. The Physiotherapist confirmed that their interaction with a resident following a fall begins when they receive a referral from nursing staff.
ii) Staff in the home did not comply with the above noted direction when there was no evidence in the clinical record that following fall incidents experienced by resident #016 on two identified dates in 2016, that nursing staff notified the Rehab/Restorative Therapist that the resident had experienced a fall and an assessment was not completed.
c) The above noted documents directed that "the resident will be assessed after each fall using the Risk Incident Management (RIM) assessment as part of the home's quality management activities related to falls".
DOC #609 confirmed that it is the expectation that when a resident experienced a fall staff were to complete the Risk Incident Management (RIM) report.
i) Staff did not comply with this direction when it was confirmed by DOC #608 that they were unable to provided RIM reports for the fall resident #013 experienced on an identified date in 2017.

2. The home provided a procedure identified as “Resident Care and Services Manual”, section “Resident Special Needs”, subject “Falls Prevention Program”, I.D. RCS-G-40, last revised on March 10, 2017.

This procedure directed "the Falls Prevention Program will be evaluated annually to measure its effectiveness and to ensure it remains effective of evidenced based practices, legislative provisions and individual needs".
Staff in the home failed to comply with this procedure when it was confirmed by registered staff #613 that an annual review was not completed in accordance with the Quality Program requirements for the 2016 calendar year. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

At the time of this inspection the home provided, what was identified as their policy and procedure related to the prevention of abuse and neglect of residents. The document provided was identified as: Resident Care and Services Manual, section-Resident Rights, subject – Abuse and Neglect Policy – RCS P-10 last revised on July 2, 2015.

The licensee failed to comply with the directions contained in the above noted policy when staff failed to comply with the following directions contained in the

policy:
1. The home will immediately investigate any allegations of harm or potential harm to a resident, including as caused by abuse, neglect, and will thereafter take all appropriate actions.

Staff failed to comply with this direction when DOC #609 confirmed they were unable to provide documentation that staff had investigated the following incidents:
- A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2016.
- An allegation made by a co-resident that an identified resident engaged in a physical altercation with them on an identified date in 2017.
- A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2017.

2. Any 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 was based to the Director of Long-Term Care Homes, including abuse of a resident by anyone.

Staff failed to comply with this direction when DOC #609 confirmed that they did not report the following incidents in accordance with the policy:
- A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2016.
- An allegation made by a co-resident that an identified resident engaged in a physical altercation with them on an identified date in 2017.

3. Upon discovering an incident of suspected or witnessed abuse, a staff member is to prepare a written report (Suspected Abuse/Neglect Report) which contains: what occurred; when it occurred; who was involved, including witnesses: where it occurred and any other relevant information.

Staff failed to comply with this direction when DOC #608 and DOC #609 confirmed staff had not completed the written report identified in the policy for the following incidents:
- A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2016.
- An allegation made by a co-resident that an identified resident engaged in a physical altercation with them on an identified date in 2017.

4. Any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the Administrator/designate of the home, who will immediately commence and investigation (in accordance with the directions identified in the policy).

Staff failed to comply with the directions for an investigation when DOC #608, DOC #609 and documentation confirmed the following:

a) The Administrator/designate failed to follow directions to interview the resident.

i) At the time of this inspection staff were unable to provide documentation to confirm that a co-resident was interviewed following a physical altercation with an identified resident that occurred on an identified date in 2016.
ii) At the time of this inspection staff were unable to provided documentation to confirm that a co-resident was interviewed following an alleged physical altercation with an identified resident.

b) The Administrator/designate failed to immediately notify police of any alleged, suspected or witnessed incident of abuse of a resident that may constitute a criminal offence.
i) At the time of this inspection staff were unable to provide documentation to confirm that the police were contacted following a witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2016.
ii) At the time of this inspection staff were unable to provide documentation to confirm that the police were contacted following an alleged physical altercation between an identified resident and a co-resident that occurred on an identified date in 2017.

5. The Administrator/designate failed to follow the process identified in the policy for conducting an investigation.

- At the time of this inspection DOC #608, DOC #609 and documentation confirmed that an investigative team had not been assembled, relevant documents had not been gathered, interviews had not been conducted/documented in accordance with the policy, there was no evidence to confirm decisions related to the incidents had been made and the outcome of the investigation had not been communicated to the parties identified in the policy related to the following incidents:

i) A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2016.
ii) An allegation made by a co-resident that an identified resident engaged in a physical altercation with them on an identified date in 2017.
iii) A witnessed physical altercation between an identified resident and a co-resident that occurred on an identified date in 2017.

6. The policy is to be reviewed on at least an annual basis to evaluate its effectiveness, including whether any changes are necessary, the review is to include an analysis of every incident of abuse/neglect including the investigation of the incident.

Registered staff #613 and documentation provided by the home confirmed that the annual evaluation of the licensee’s policy had not been completed as specified in the policy for the 2016 calendar year. [s. 20. (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 ensuring that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

1. An investigation into a witnessed physical altercation between an identified resident and co-resident was not conducted.

On an identified date in 2017, a registered staff member documented in the identified resident's clinical record that this resident had an altercation with a co-resident. A review of the identified resident's clinical record confirmed that there was no further notation in the clinical record that would indicated that the residents were interviewed following the incident noted above or that an investigation had been initiated.
Clinical documentation confirmed that there was no notation in the co-resident's clinical notes about the altercation, that the resident was interviewed related to the incident or monitored subsequent to the altercation for injury. The co-resident confirmed that staff did not speak to them about the incident.
DOC #609 confirmed that they were unable to provide documentation to confirm that the above noted incident was investigated.

2. An investigation into a witnessed altercation between an identified resident and a co-resident was not investigated.

On an identified date in 2017, a registered staff member documented in an identified resident's clinical record that it was reported by a witness that the resident engaged in a physical altercation with a co-resident. The registered staff person documented that the charge nurse and DOC #609 were notified of the incident. Clinical documentation indicated that an investigation had been initiated. There was no further documentation in either resident’s clinical record that would indicate that the residents were interviewed subsequent to staff documenting the altercation.
DOC #609 confirmed that they were unable to provide documentation to confirm that the above noted incident was investigated.

3. An investigation into an allegation of a physical altercation between an identified resident and a co-resident was not completed.

On an identified date in 2017, a registered staff member documented in the identified resident's clinical record that a co-resident reported to them that the identified resident had engaged in a physical altercation with them. Staff documented that there was no injury noted to the co-resident and the on-call manager was contacted. The note also indicated that DOC #609 was contacted and that they would follow-up the following day, but there was no indication in the note that an investigation had been initiated.

On an identified date in 2017, DOC #609 noted in a co-resident’s clinical record that they had been advised of an altercation between the co-resident and the identified resident, they were unable to verify if physical aggression occurred or whether the incident was verbal as there were no witnesses. DOC #609 also documented that they would speak to both residents the following day to ascertain what had transpired. A review of both the co-resident's and the identified resident's clinical records confirmed that there was no documentation of further contact with either resident about the alleged physical altercation.
DOC #609 confirmed that they were unable to provide any documentation to confirm that the allegation made by the co-resident were investigated. [s. 23. (1) (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 and ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to meet the needs of residents with compromised communication, verbalization skills and residents who cannot communicate in the language or languages used in the home.

The licensee failed to develop and implement strategies to meet the communication needs demonstrated by an identified resident.

- On an identified date in 2016 an outside consultant identified communication related issues as a care focus for the resident and a basic communication strategy was presented to the resident who did not respond to the strategy.
- On an identified date in 2017 DOC #609 and the Social Worker met with the resident and the resident family member. Documentation of this meeting indicated that participants discussed communication related issues and two strategies were discussed. DOC #609, registered staff #618, clinical documentation and observations made during this inspection confirmed that the two communication strategies discussed were not implemented.

Interviews conducted at the time of this inspection with DOC #608, DOC #609, RN #601, RPN #614, PSW #615 and PSW #616 confirmed that staff who knew the identified resident and provided care to the resident were aware of the resident's communication related issues.

DOC #609 confirmed strategies and care interventions had not been implemented to address an identified communication care need identified by the identified resident. [s. 43.]

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 and ensuring that strategies were developed and implemented to meet the needs of residents with compromised communication, verbalization skills and residents who cannot communicate in the language or languages used in the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodations, care, services, programs, and goods provided to residents of the long term care home.

The licence's’ quality improvement program was documented in the following policy/procedure documents:
a) Annual Schedule of Risk and Quality Improvement Tools – Overview of Annual Schedule – QIP B-05, last reviewed March 14, 2017.
b) Additional Quality Programs – Documentation of Quality Improvements/Risk Management Activities – QIP C-25, last reviewed March 14, 2017.
c) Management of Information Systems – Evaluation Summary Report – QIP H-20, last reviewed November 8, 2011.
d) Introduction – Quality Improvement Plan – QIP A-20-25, last reviewed on March 14, 2017.

The above noted documents set out the following process to be followed for the implementation of the licensee’s quality improvement program:

1. The production of a yearly schedule of quality activities provided to each department/program/service area the implementation of which was to be monitored

by each department supervisor, the home's Quality Improvement Committee and the Quality Council.
2. After completion of audits, the annual evaluation of internal programs and the review of evidenced-based or prevailing practices, the department head together with his/her team complete the evaluation summary report.
3. Areas identified as deficient or in need of improvement are noted in the summary report. Strategies and/or actions to be implemented are documented with target dates and the names of the persons or teams responsible for the implementation.
4. At a minimum a written plan for the home's quality improvement program, written plan for the implementation of the plan and identified documentation for the identification of quality improvement initiatives needs to occur in each home.
5. The annual quality improvement plan must be developed considering at least the results of satisfaction surveys/other client processes such as concerns/complaints, quality of life indicators and home specific indicators, critical incidents both operational and resident care related, inspection reports and results, strategic priorities and results of the evaluations of programs and services as per the LTCHA, 2007 and Ontario Regulations 79/10.

The licensee failed to implement a quality and utilization review system when staff failed to implement directions contained in the licensee's quality improvement program.

Director of Care #609, registered staff #613 and documents provided by the home confirmed:
i) The implementation of the quality process was not monitored in accordance with directions contained in the licensee's policies.
ii) Evaluation summary reports were not completed following the above noted audits.
iii) The 2016/2017 Annual Quality Improvement Plan was not developed considering quality improvement activities related to inspection reports as was required, in particular, previously issued compliance orders related to protection from abuse/neglect, documentation of care provided to residents and issues related to bed safety.

Staff and documents provided by the home confirmed that the Quality Improvement Program was not implemented in the home in accordance with the policies and processes identified in the licensee's policies [s. 84.]

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 and ensuring the implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodations, care, services, programs, and goods provided to residents of the long term care home, to be implemented voluntarily.

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

Findings/Faits saillants :

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

The licensee failed to notify the appropriate police force of a witnessed and an alleged incident of resident abuse.

1. At the time of this inspection a co-resident was able to recall an incident that happened on an identified date in 2016, when an identified resident engaged in a physical altercation with them. Documentation in the identified resident's clinical record indicated that a registered staff member had witnessed the altercation between the two residents. DOC #609 confirmed that police were not contacted when it was witnessed that an identified resident engaged in a physical altercation with resident #005.

2. Clinical documentation indicated that a co-resident made an allegation to a registered staff member that an identified resident had engaged in a physical altercation with them on an identified date in 2017. Documentation made by the registered staff member provided details of the incident and indicated that DOC #609 had been contacted about the incident. DOC #609 confirmed that police had not been contacted when the co-reisdent alleged that an identified resident engaged in a physical altercation them. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the appropriate police force was immediately notified of any alleged, suspected or witnessed incidents of abuse of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #11: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 failed to ensure that the Infection Prevention and control program was evaluated and updated at least annually in accordance with evidenced-based practices and if there are none, in accordance with prevailing practices.

In response to a request to provide the annual evaluation of the Infection Control and Prevention Program for the 2016 calendar year an audit document was provided which had been completed by DOC #609. Registered staff #613 confirmed that the home's quality program directed that staff were to complete audits and then complete a summary report of information gathered in the audit in order to complete an annual review of the program in the home. DOC # 609 and registered staff #613 confirmed that staff had not completed a summary report based on the audit completed and an evaluation of the program for the 2016 calendar year had not been completed. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

Registered staff #617 and observations made during the inspection confirmed that staff had not participated in the implementation of the Infection Prevention and Control Program when they did not dispose of soiled incontinent products or store urine/stool collection equipment in accordance with identified infection control practices in the home. During a tour of the first floor home area with registered staff #617 it was confirmed that staff disposed of soiled incontinent products in waste baskets beside resident beds, in the waste baskets in resident washrooms and also stored urine/stool collection equipment on grab bars in resident washrooms and in one case on top of a waste basket beside a resident's bed. Registered staff #617 confirmed that staff had been instructed during training and it was the practice in the home to dispose of soiled incontinent products in the appropriate container in the soiled utility rooms on each home area and it is not an appropriated infection control practice to store urine/stool collection equipment on grab bars in resident's washrooms. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that all staff participated in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Falls Prevention and Management program identified under O. Reg. 79/10, s. 48 (1) 1, was evaluated and updated at least annually in accordance with evidenced base practices and, if there are none, in accordance with prevailing practices.
Registered staff #613 confirmed that the Falls Prevention and Management Program was not evaluated for the 2016 calendar year. [s. 30. (1) 3.]

WN #13: 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 failed to ensure that procedures and interventions were implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviour.

Director of Care (DOC) #609 and clinical documentation confirmed that procedures were not implemented to assist residents who were at risk of being harmed as a result of a co-resident who demonstrated aggressive and threatening responsive behaviours.
Six incidents documented in clinical records were reviewed with DOC #609 that included:

-A co-resident engaged in a physical altercation with resident #005.
-A co-resident engaged in a physical altercation with resident #008
-A co-resident engaged in a physical altercation with resident #012
-A co-resident engaged in a physical altercation with resident #006
-A co-resident engaged in a physical altercation with resident #009
-A co-resident engaged in a physical altercation with resident #011

The above notes residents were identified as being cognitively alert and were not provided with assistance or support following the above noted altercations with a co-resident [s. 55. (a)

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of resident, and what changes and improvement were required to prevent further occurrences.

Staff #613 and documents provided by the home confirmed that the home did not complete an evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents or what changes and improvements were required to prevent further occurrences, for the 2016 calendar year. [s. 99. (b)

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriated to the risk level of the drugs.

Staff in the home submitted a referral to an out-of-home consulting physician following an altercation an identified resident had with a co-resident. The consulting physician visited the resident eight days later and ordered a change in the resident's medications. The new order directed that two medications the resident had previously taken were to be stopped and a new order was written for a medication to be administered twice a day for a two week period and then the afternoon dosage of the medication was to be increased.

DOC #609 and the clinical record confirmed that staff took no action to monitor or document the resident's response to the new medication or the effectiveness of the medication related to behavioural symptom control. [s. 134. (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the training and orientation program for the home was evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Staff # 611 and documentation provided by the home confirmed that an evaluation of the training and orientation program for the home was not completed for the 2016 calendar year. [s. 216. (2)]

Issued on this 31 day of August 2017 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)

Inspection No. / No de l'inspection : 2017_587129_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 016419-16, 034944-16, 000624-17, 002569-17, 005832-17, 008800-17, 009016-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 31, 2017;(A1)

Licensee / Titulaire de permis : RYKKA CARE CENTRES LP
3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2

LTC Home / Foyer de SLD : DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Leslie Watson

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_322156_0006, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee is to ensure that all residents, including two identified residents, are protected from abuse.

2. The licensee is to develop and implement a face to face training program for all staff related to the prevention of abuse. The training program is to include a review of the sections of the Long Term Care Home Act 2007 and Ontario Regulation 79/10 that deal specifically with the requirements related to abuse as well as what systems are in place or will be put in place in the home to ensure compliance with those requirements. The home is to maintain specific subject matter and attendance records for this training.

3. The licensee is to review the home's policies and procedures related to the prevention of abuse and neglect and where necessary revise these documents to ensure that they provide clear direction to staff related to the actions to take when staff suspect a resident may have been abused, staff receive an allegation of abuse or staff witness abuse.

Grounds / Motifs :

1. The licensee failed to comply with order #003 issued during Resident Quality Inspection #2016_322156_0006 served on June 3, 2016.

This Order is based on the application of the factors of severity (2), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm to residents, the scope of a pattern of incidents and the licensee's history of non-compliance that included the issuing of voluntary plans for corrective action on February 27, 2014, March 30, 2015, April 19, 2016 and a compliance order served on June 3, 2016.

2. The licensee failed to protect three identified co-residents from emotional abuse.

In accordance with O. Reg. 79/10, s. 2(1) emotional abuse is defined as "any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviours or remarks understands and appreciates their consequences".

An identified resident's clinical record confirmed that in the opinion of the resident's Physician, the identified resident's mental/emotional state was normal. Interviews staff who knew the resident well and provided care to the resident confirmed that it was their opinion that the identified resident understood and appreciated the consequence of their actions.

a) During an interview a co-resident disclosed that they did not feel safe in the home and had not felt safe in the home for some time. On an identified date in 2016, documentation in an identified resident's clinical record indicated that the identified resident engaged in a altercation with the co-resident. A review of identified co-resident's clinical record indicated that there was no documentation of the incident that occurred on the identified date. During the interview the co-resident was able to recount the incident. During the interview with the co-resident they disclosed that they did not feel safe in the home, had not felt safe for some time and their approach was to try to avoid contact with the identified resident.
The co-resident experienced emotional abuse when they described being fearful and feeling unsafe both following an altercation initiated by the identified resident and currently when they identified their strategy was to avoid contact with the identified resident whenever possible. It was confirmed in clinical records and by staff who know and provide care to the identified resident that the resident understood and appreciated the consequences of their actions.

b) During an interview a co-resident disclosed that they did not feel safe in the home as a result of actions by an identified resident.

Clinical documentation made in 2017, indicated that an identified resident engaged in a altercation with a co-resident. During the interview, the co-resident was able to recounted the incident as it was described in clinical documentation and during the discussion the resident disclosed that they did not feel staff in the home as a result of the altercation with the identified and another resident.
The co-resident experienced emotional abuse when they described being fearful and feeling unsafe following an altercation when with an identified resident. The co-resident continued to be fearful of further altercations with the identified resident when they indicated that their strategy was to try and stay away from the identified resident. It was confirmed in clinical records and by staff who know and provide care to the identified resident, that the resident understood and appreciated the consequences of their action.

c) A review of a clinical note, made on an identified date in 2017, by the Registered Nurse working at the time, indicated that an identified resident engaged in an altercation with a co-resident.
The above noted clinical note and an Internal Risk Report indicated that the co-resident sustained an injury as a result of the altercation. DOC # 609 and clinical documentation confirmed that the co-resident indicated they no longer felt comfortable or safe following the altercation with the identified resident.
The co-resident experienced emotional abuse when they described to DOC #609 that following the incident when with the identified resident they no longer felt comfortable or safe in the home.

The licensee failed to protect resident three identified co-residents from abuse when:

-The licensee failed to develop or implement strategies to address and manage physically aggressive behaviours demonstrated by an identified resident.
-The licensee failed to reassess an identified resident when their care needs changed and the resident demonstrated an increase in responsive behaviours.
- The licensee failed to develop communication strategies for an identified resident.
-The licensee failed to take action to minimize the risk of altercations between residents, particularly in areas of the home were altercations between residents had been known to occur.
-The licensee failed to interview identified residents following incidents where two co-residents were involved in altercations with an identified resident in order to determine the co-resident's response to the altercations and to determine if the co-

residents required support to deal with their fear of further altercations.
-The licensee failed to complete an annual evaluation for the 2016 calendar year of the of the items required in O. Reg. 79/10, s. 53(1) to meet the needs of residents with responsive behaviours.
-The licensee failed to complete an annual evaluation for the 2016 calendar year of the effectiveness of the licensee’s policy to promote zero tolerance of abuse of residents or to determine what changes and improvements needed to be made.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Oct 16, 2017(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Order / Ordre :

1. The licensee is to develop and implement a policy, procedure and tool to be used when attempting to identify possible triggers for responsive behaviours being demonstrated by residents.

2. The licensee is to provide face to face training for all staff related to the implementation of the above noted tool. The home is to maintain specific subject matter and attendance records for this training.

3. The licensee is to implement the above noted tool and reassess all residents who demonstrate responsive behaviours for possible triggers for each responsive behaviour demonstrated. Plans of care are to be developed, implemented and evaluated related to the management of identified behavioural triggers.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (2) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm to residents, the scope of a pattern of incidents and the licensee's history of non-compliance.

2. The licensee failed to ensure that written approaches to care as well as resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours.
At the time of this inspection documents provided by the home that were identified as directions for staff related to the management of responsive behaviours included:
a) Quality Improvement Program – Nursing/Resident Care Annual Evaluation-Behaviour Management Program and Responsive Behaviour Philosophy- QIP I-05-05, last reviewed January 10, 2017
b) Resident Care and Services Manual – Resident Special Needs – Behavioural Management & Responsive Behaviour Philosophy and Assessment – RCS G-45-05, last revised July 15, 2013
c) Quality Improvement Program – Nursing/Resident Care Audit & Evaluation – Behaviour (Including Responsive Behaviour) Management and Audit and Evaluation – QIP I-10-10, last reviewed on November 8, 2011.

A review of the above noted documents indicated that the documents referred to "triggers for behaviours" but did not provide written approaches for staff to follow in the assessment of responsive behaviours and specifically the process to follow to identify possible triggers for responsive behaviours that were demonstrated by residents.

Clinical records reviewed for three identified residents, confirmed that these residents were identified to demonstrate responsive behaviours and there was no clinical documentation to indicate that an attempt to identify triggers for the specific behaviours being demonstrated by these residents was completed.

Director of Care (DOC) #609 confirmed that the home did not utilize a tool or a process for the identification of possible triggers for responsive behaviours and there were no written approaches for staff to follow. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Oct 16, 2017(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

1. The licensee is to take steps to minimize the risk of altercations between identified residents.
2. The licensee is to identify possible situations in the home that may lead to potentially harmful interactions between the identified residents.
3. The licensee is to put in place strategies to manage those identified situations.
4. The licensee is to develop and implement a face to face training program for staff who provide direct care to the identified residents related to minimizing altercations and potentially harmful interactions between and amongst residents. The home is to maintain specific subject matter and attendance records for this training.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (2) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm to residents, the scope of a pattern of incidents and the licensee's history of non-compliance with issues related to the management of responsive behaviours.

2. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

a) An identified resident's clinical record and staff providing care to the resident confirmed that the resident engaged in altercations with co-residents.

i) On an identified date in 2016, staff documented an altercation between an identified resident and an identified co-resident. At the time of this inspection the co-resident was able to recalled the incident. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.
ii) On an identified date in 2016, staff documented an altercation between an identified resident and a co-resident. Clinical documentation indicated that following this incident staff offered the identified resident the option of relocating and the resident refused. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.
iii) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.
iv) On identified date in 2017, an identified resident initiated an altercation with a co-resident. During an interview the co-resident recounted the incident (as was documented in the clinical record) to the inspector. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.

v) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. An Internal Risk Report indicated that the co-resident sustained an injury. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of type of altercation.
vi) On an identified date in 2017, an identified resident initiated an altercation with a co-resident. DOC #609 and clinical documentation confirmed that an interdisciplinary assessment was not completed following this incident and staff did not identify or implement interventions to prevent a reoccurrence of this or a similar altercation.

b) Clinical documentation indicated that on an identified date in 2016, an identified resident engaged in an altercation with a co-resident. Documentation indicated that there was no injury to the co-resident. Clinical documentation indicated that on an identified date in 2017, the identified resident and the co-resident engaged in another altercation in which the co-resident sustained an injury. DOC #609 and the clinical record confirmed that a referral to an out-of-home consultant was made for the identified resident following the altercation in 2016, but that staff were not provided with any care directions or other steps to minimize the risk of further altercations either after the 2016 altercation or the 2017 altercation.
The licensee did not take steps to minimize the risk of altercations and potentially harmful interactions between residents. (129)

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

Oct 16, 2017(A1)

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 31 day of August 2017 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office / Bureau régional de services : Hamilton