Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, 2016	2015_291552_0024	O-002656-15	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TAUNTON MILLS
3800 Brock Street North WHITBY ON L1R 3A5

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

MARIA FRANCIS-ALLEN (552), CHANTAL LAFRENIERE (194), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 13,14,15,16, 19, 20, 21,22,23 & 26, 2015

Also inspected during the Resident Quality Inspection:
Follow up log #O-002515-15 related to resident abuse, Complaint log #O-001634-15 related to responsive behaviours, O-001857-15 related to plan of care, O-002046-15 related to infection control, Critical Incident Log # O-002296-15 and O-001641-15 related to staff to resident abuse, and O-001797-15 related to falls were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with General Manager, Assistant General Manager, Director of Care (DOC), Neigbourhood Coordinators, Director of Recreation, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA) Physiotherapist (PT), Occupational Therapist (OT),Kinesiologist, Dietary, Housekeeping, President of the Resident Council and Family Council, residents and family.

Also toured the home, observed dining service, medication administration, infection control practices, staff to resident interaction during provision of care. Reviewed clinical health records, relevant policies - Prevention of Abuse, Medication Administration, Falls Prevention, Responsive Behaviours, Skin and Wound, minutes from Family and Resident Council meetings.

The following Inspection Protocols were used during this inspection:

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:

Under O. Reg 79/10 s. 2(1) Physical abuse definition: -- (c) "the use of physical force by a resident that causes physical injury to another resident"

A review of the home's critical incident report (CIR) log for incidences occurring after an identified date was conducted. The following information was found:

Review of the CIR describing that resident #059 hit resident #058. Resident #058 sustained a minor injury. The incident occurred on an identified date; the Director was notified 9 days after the incident.

Regarding Resident #053

Under O. Reg 79/10 s. 2(1) Emotional abuse definition :
-(a)"any threatening insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident ".

The review of CIR of an alleged staff to resident emotional abuse that occurred on an identified date was submitted to the Director three days later.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19 was issued during inspection #2015_396103_0043 which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1), with a compliance date of September 1, 2015.

The decision to issue a Compliance Order (CO #001) for the second time is based on two separate occasions on identified dates where under the legislative requirements, immediate notification to the Director was to be completed and the licensee failed to report. (194) [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an assessment of the resident and the resident's needs and preferences.

Regarding Resident #055 related to log # 001857-15
A complaint was received from resident #055's POA indicating that on an identified date,

the resident had a change in his/her medical condition which was reported to RPN #150. The staff member responded and determined a different intervention than what was requested by the POA would be used. The resident's condition appeared to deteriorate.

The complainant is upset that the resident's medical condition had deteriorated and a different intervention as requested by the POA was not provided.

Interview with the General Manager #162 (GM) and DOC #101 who had reviewed resident #055's clinical health records indicated there was a change in the resident's care needs and alternative interventions were available according to the plan of care. [s. 6. (2)]

2. Related to Intake #O-002916-15, for Resident #022:

The licensee failed to comply with LTCHA, 2007, s. 6 (5), by not ensuring that the substitute decision maker (SDM), has been provided the opportunity to participate fully in the development and implementation of the plan of care.

One of resident #022's SDM voiced concerns, to the inspector, that the SDMs were not consistently notified by the home of incidents involving resident #022.

A review of resident #022's clinical health record for a nine month period, provides details that resident #022 had approximately twenty falls; the clinical health review showed that staff notified other relatives, who were not designated as SDM's.

The AGM and DOC indicated (to the inspector) the expectation is that the SDM is to be notified of health changes and or concerns relating to residents. [s. 6. (5)]

3. Related to Resident #061:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, specific to activities of daily living (ADL).

Resident #061's written plan of care indicated the resident was dependent on staff for ADLs.

The Neighbourhood Coordinator indicated the family of resident #061 complained to RAI-

Coordinator and another Neighbourhood Coordinator the resident had requested assistance with ADLs and waited for approximately one hour and that, PCA #153 refused to provide care to the resident.

Emails provided to the inspector by the Neighbourhood Coordinator, indicated PCA #153 refused care to Resident #061 on two identified dates due to the resident's inappropriate responsive behaviours.

The Neighbourhood Coordinator indicated that staff are not permitted to refuse care to any residents and that there were interventions in resident #061's plan of care, to have two staff present if resident was exhibiting inappropriate responsive behaviours. (554) [s. 6. (7)]

4. Related to Intake #O-002916-15, for Resident #022:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care provided to the resident as specified in the plan, specific to falls prevention and management.

Resident #022 is reliant on staff for ADL; but will participate in transfers. The resident is identified as being moderate to high risk for falls.

The plan of care indicates the following:
- Transfers and toileting – requires extensive assistance with one to two staff to transfer and when getting up and extensive assistance of two staff for toileting;to be toileted before and after meals and as needed.

The clinical health record for a nine month period, detailed that resident had approximately twenty falls, eleven of the falls occurred when resident was transferring unaided by staff or toileting self, four falls occurred when resident was trying to get up from lounge chair.

A progress note in resident #022's health record, written on a specific date, indicates the resident requested assistance with transfer, staff did not assist the resident with transfer.

The Neighbourhood Coordinators indicated the expectation is that staff provide care as per the plan of care.(554) [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care for one to one monitoring for resident #045 was provided as specified in the plan.

In July 2015 an immediate order was issued to the home for one to one monitoring to be initiated for responsive behaviour exhibited by resident #045.

A review of the progress notes for resident #045 related to responsive behaviours for a three month period indicated:

Resident #045 had moved to another neighborhood (unit) on an identified date with continued one to one in place for a specific time frame.

A "late entry" in the progress notes indicated the DOC received a call saying resident #045 was being redirected back to the bedroom as the resident has been left unattended in the lounge area.

During an interview with Inspector #194 and #552, the GM and DOC indicated that although one to one monitoring was in place for resident #045 (at the time of the incident), the PCA had left resident #045 unattended.

The care set out in the plan for one to one monitoring to be in place for resident #045 was not provided as specified placing co resident at risk. [s. 6. (7)]

6. Related to Intake #O-002916-15, for Resident #022:

The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by not ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, related to falls prevention and management.

The resident's SDM indicated (to the inspector) concerns had been voiced to staff as to the number of falls resident #022 was having; the SDM had asked that a bed alarm be initiated, but was told the alarm would not be heard due to the location of the resident's room. The SDM asked if the resident could be re-located but was told no rooms were available.

A review of resident #022’s clinical health record, indicates the resident had approximately 18 falls (and two near misses) over a nine month period.

The written care plan, for resident #022, (over a nine month period), details resident care needs, specific to transferring, toileting, locomotion and falls risk:

- Transferring – requires extensive assistance to transfer by one staff; revised on a specific date to include one to two staff extensive assistance with transfers ; resident has unsteady balance; participates in transfers and uses mobility device. Interventions were revised six months later, to include, resident requires extensive assistance of one to two staff depending on resident's condition and behaviours; resident is non-compliant and forgets to ask for assistance with transferring.

- Toileting – Interventions include, requires extensive assistance of one staff; interventions were revised to include, two staff to assist resident at specific times and as needed.

- Locomotion – walks independent with mobility device; interventions were revised, to include, when resident is feeling well, a different mobility aide would be used.

- Falls Prevention and Management – moderate risk of falls, related to medical condition and medications. Interventions included several strategies to reduce the risk of falls and included the use of a device to prevent the resident from sliding out of his/her chair and the use of chair and silent bed alarms.

The Kinesiologist, who is the lead for the home's Falls Prevention and Management Program indicated , the resident was at moderate to high risk for falls, and the resident should have been on a toileting program, The resident's health condition changed three months ago, and at that time, the resident became "high" risk for falls.

PCA #180 indicated (to the inspector) that resident #022 often fell when attempting self-transfer or to get to the washroom. PCA #180 indicated resident should have been toileted before and after meals and as needed.

PCA #180, RPN #110 and resident's attending physician indicated (to the inspector) the home initiated a silent bed alarm (in the past month) for resident #022 in an effort to prevent falls; They all indicated that a bed alarm had not been initiated prior to this date, as the regular bed alarms used would not have been heard due to the location of the resident's room.

A review of progress notes, written care plan, fall incident reports, post-falls assessments and interviews with PCA and the Kinesiologist indicated changes were made to the care related to toileting and transfers. A referral was also initiated to physiotherapist to assess for tilt wheelchair, chair alarm and device to prevent sliding. Note: resident #022 had ten falls by a specific date.
- Chair Alarm was removed a couple months later as resident was beginning to walk again and spending less time in wheelchair.
- Silent Bed Alarm – initiated on a specific date. Note: resident #022 had 17 falls by this time, eleven falls in which resident was attempting to get out of bed.

A review of resident #022's health record and interviews with PCA, RPN, Kinesiologist and Physician fails to provide evidence that: revisions had been made to resident's plan of care specific to toileting needs; interventions specific to checking resident's safety at a specific time or when in bed were in place. The silent bed alarm intervention was not implemented until a couple months later. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the written plan of care for each resident sets out (a) the planned care for resident and the goals the care is intended to achieve; that the plan of care is based on an assessment of the resident and the resident's needs and preferences;the care set out in the plan of care is provided to the resident as specified in the plan and the resident is being reassessed and the plan of care is being revised when care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Under O. Reg. 79/10. s. 114 (2) it states "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home".

Review of Medication policy titled "Self Administration of Medication" Tab 05-31 last reviewed January 2015
Under the subtitle Procedure" points number 7 and 8 indicated:
- Each month, when the MARS are recorded, the Team Leader will review the self-administered medications taken by the Resident to ensure a current record is kept. The Team Leader will re-order medication from the Pharmacy when requested by the Resident and note date and amount ordered.

- The Self-Administration of Medication Assessment will be placed on the resident's chart with the physician's order or in the MAR.

Residents #034, 056 and 057 were identified as able to self administer specific medications. The Medication Administration Record (MAR) for each of the three residents had written across the form "self administered".
Upon review of the resident's MAR folder and health records, the inspector was unable to find the self administration assessment form outlined in the home's policy.

During an interview, with the Neighbourhood Coordinator #127, she indicated that residents who have been deemed to be capable of self administering medications should have a completed self-administration of medication assessment form as outlined in the policy.

Interview with Neighbourhood Coordinator #127 and RPN #161 both confirmed these self administration assessment forms could not be found in the resident's charts with the physician's order or in the MAR. Therefore the licensee has failed to comply with their policy as it relates to self administration of medication. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the medication policy put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 36 when Resident #052 was transferred with a mechanical lift by PCA # 143 using unsafe transferring technique, which resulted in the resident sustaining an injury.

Regarding log # O-001797-15 related to Resident #052

A CIR was submitted by the home indicating that on an identified date, resident #052 was transferred by PCA #143 and PCA #154 using a mechanical lift. During the transfer resident #052 was injured and was transferred to the hospital.

During an interview with Kinesiologist #137 by the inspector, it was confirmed the resident was to be transferred using a specific size device and the staff used a different size.

During an interview both RPN #125 and the DOC indicated to the inspector, the incorrect sized device was used during transfer resulting in an injury to resident #052. [s. 36.]

Additional Required Actions:

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

WN #5: 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 are taken to minimize the risk of altercations and potentially harmful interactions between Resident # 044 and #045.

Regarding log # O-002296-15 related to Resident #044

Resident #044 indicated (to the inspector) that he/she voiced complaints to the nursing staff, he/she was upset that resident #045 was continuously being disruptive during the night and exhibiting inappropriate responsive behaviours. The resident indicated he/she slept in the lounge on at least three occasions due to resident #045's behaviours.

Resident #044 indicated these concerns were reported to staff and the response received was there was nothing that could be done to resolve the resident's concerns.

A review of progress notes for resident #044, for a 2 month period, confirmed the information provided to the inspector by the resident.

The Neighbourhood Coordinator and the AGM indicated (to the inspector) being aware that resident #044 had been upset by the interactions. They both indicated resident #045 "meant no harm" to resident #044, indicating resident #045 was "merely was trying to find his/her way to the washroom".

The licensee failed to ensure that steps were taken to minimize the risk of altercation between Resident #044 and #045.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_396103_0043, which included a written notification specific to LTCHA, 2007, s. 24(1); the incident involving this resident was prior to the compliance due date of September 01, 2015. No further action will be taken. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 101 (1) 1, by not ensuring every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
- has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
- where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

The home's policy, Family and Resident Concerns (#11-21) directs that if a family member or resident expresses a concern to a team member, the team member will notify the Neighbourhood Coordinator or designate in writing by way of an incident report form. The Neighbourhood Coordinator or designate will contact the family or resident on the same day to clarify the concern and acknowledge that the concern has been received; if the concern is relatively easy to remedy, the Manger will advise the family member or resident how and when this will be done; If the concern requires more investigation, the Neighbourhood Coordinator will indicate to the family member or resident when such an investigation will be completed. The Neighbourhood Coordinator will contact the family member or Resident within five working days of the commencement of the investigation, unless the complaint alleges harm, to discuss the result of the investigation and remedial action if any. The contact will be made by phone or, if it is a significant issue, by way of a meeting. If the complaint alleges harm, the investigation will commence immediately to ensure safety.

A review of the home's Family Complaints binder, provided to the inspectors by the DOC indicated there were four complaints (three verbal and one written) made to the management team by residents and family members.

Within the Family Complaint's binder a written complaint, was brought to the attention of a Neighbourhood Coordinator. The Neighbourhood Coordinator did not follow up with the resident's family until thirteen days later as to interventions identified and or implemented.

The AGM indicated (to the inspector) the resident or family should have been contacted regarding complaints and or concerns within seven to ten business days and the response to this specific complaint was outside of the home's normal time frames for a complaint response.

2. Related to Intake #O-002296-15, for Resident #044:

During an interview resident #044 indicated (to the inspector) that he/she voiced complaints to the nursing staff that he/she was upset that resident #045 was continuously being disruptive during the night and exhibiting inappropriate responsive behaviours.

A review of progress notes for resident #044, for a two month period, confirmed the information provided by the resident.

Resident #044 indicated (to the inspector) the concerns/ complaint regarding resident #045's behaviours were not being addressed. Resident #044 indicated being told by staff and the AGM, there was nothing that could be done, as it was felt that resident #045 did not mean any harm.

The AGM and Neighbourhood Coordinator both indicated (to the inspector) being aware of resident #044 complaints/concerns.

Resident #045 was eventually transferred to another neighbourhood (unit); this intervention was implemented 59 days after resident #044's first complaint to staff.

3. Related to Resident #009:

Resident #009 voiced concern (to the inspector) during the first week of the RQI, about the temperature in their room.

A review of the Resident Council Meeting Minutes, indicated members of the council, specially resident #009 voiced complaints of the home being cold; as per the meeting minutes this concern was later resolved.

Resident #009 indicated the verbal complaint regarding the temperature in the room remains unresolved.

4. Related to Resident #004:

Resident #004 uses a mobility aide for long distances, including going outdoors.

Resident #004 indicated (to the inspector) having difficulty getting back into the home

from outdoors due to wheelchair accessibility at the main entrance and also from the outdoor resident patio on specific neighbourhood (unit). Resident #004 indicated (to the inspector) the home is aware of this concern and it has also been raised by Resident Council Members on more than one occasion.

A review of the Resident Council Meeting Minutes provides evidence that members of the Resident Council raised concerns with wheelchair accessibility at main entrance on Main Street, as well as a specified unit on an identified date.

The Director of Recreation confirmed that Resident Council Members did bring the wheelchair accessibility concerns on June 2015 and the AGM indicated in her response to the Resident Council she would talk to the Environmental Manager about the concerns.

The AGM indicated (to the inspector) that she did bring the accessibility concerns to the Environmental Manager, but the Environmental Manager has resigned and the concern was left unaddressed.

It has been approximately 139 days since the original concern/complaint regarding the accessibility at the main entrance and a specific neighbourhood, was voiced by resident #004 and members of the Resident Council. A response from the home within 10 business days has not been received, neither has the issue been resolved. [s. 101. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), by not ensuring that there is a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and, any response made by the complainant.

Related to Resident #009:

Resident #009 voiced concerns (to the inspector) during the first week of the RQI, about the temperature in their room.

Resident #009 indicated this concern has been voiced at Resident Council Meetings, to

nursing staff, housekeeper and RAI-Coordinator.

A review of the Resident Council Meeting Minutes, indicated members of the council, have voiced complaints of the temperature within the home; as per the meeting minutes this concern was later resolved.

A review of the home's electronic resident health record , for a three month period for resident #009 failed to provide any documented evidence of concerns of the resident being recorded.

2. Related to Intake #O-002916-15, for Resident #022:

Resident #022's SDM indicated she has voiced several care concerns; the resident's SDM indicated the concerns were voiced to all nursing staff and the management of the home. The SDM indicated (to the inspector) that the concerns are going unheard.

The AGM indicated (to the inspector) that only “serious” concerns are documented in the Resident and Family Concerns binder, all other concerns or complaints are handled by the Neighbourhood Coordinators; she further explained that care concerns or concerns of a less serious nature are documented in the home’s electronic resident health record under the individual resident.

The Neighbourhood Coordinators indicated (to the inspector) that family or resident concerns maybe documented in the home's electronic resident health record but usually concerns are written on neighbourhood communication boards, discussed in team huddles and then erased; both of the Neighbourhood Coordinators indicated (to the inspector) there is no formal documentation of these team meetings nor is there any recorded concerns which were written and erased from neighbourhood communication boards.

There is no documented record of the concerns of resident #022's SDM documented in the home's Resident and Family Concerns binder or in the individual resident progress notes. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint and where the complaint alleges harm or risk to one or moreresidents the investigation is commenced immediately. The licensee shall also ensure that a documented record is kept in the home that includes: the nature of each verbal or written complaint; date the complaint was received, the type of action taken to resolce the complaint, the final resolution, every date on which any response was provided to the complainant and any response made in turn by the complainant, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. Related Intake #O-002296-15, for Resident #044

Resident #044, who is cognitively well, was upset that resident #045 was continuously being disruptive during the night and exhibiting inappropriate responsive behaviours.

Progress notes, reviewed for resident #044, for a two month period, provided details of twenty separate complaints/concerns from resident #044 concerning this matter.

The AGM and Neighbourhood Coordinator, both indicated being aware of resident #044's concerns and that the interactions made resident #044 feel uncomfortable. They both indicated a CIR was not submitted as it was not felt that Resident #045 "meant any harm".

As of October 21, 2015, the licensee had not yet submitted a CIR, specific to allegation of resident to resident abuse. [s. 104. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the report is made to the Director within 10 days of becoming aware of the alleged, suspected or witnessed incident, of neglect, or at an earlier date if required by the Director. The licensee is to also ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director)., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, (ii) that is secure and locked.

On October 14, 2015 at 0850 during observation of a resident's room, Inspector #194 observed medications on the bedside table in a private room on the secure neightbourhood.

During an interview RN #102 explained resident #002 did not have any orders to self medicate and the medication should not be at the resident's bedside. (194) [s. 129. (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 to ensure that drugs are stored in an area or a medication cart that is exclusively for drugs and drug related supplies; that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: 1. All doors that residents do not have access to must be,
i. kept closed and locked

During the initial tour on October 13, 2015 at 10:00 a.m. the inspector observed the following:
- housekeeping door unlocked on unit Dryden and unsupervised with 3 bottles of chemicals in the room

Interview with housekeeping staff #107 and DOC confirmed the above identified door should be locked at all times.

- the door leading to the servery on Clairmont neighbourhood was unlocked with hot steamers located in the area. There were residents who ambulates on this unit. Interviews with PCA #106, RPN #105, DOC and DFSM confirmed the door leading to the servery should be locked at all times. [s. 9. (1) 1. i.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by not ensuring each resident shower have at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

The following Spa Rooms (combo tub/shower) and Shower Rooms, located on specific neighbourhoods , did not contain shower grab bars consistent with the legislation:
- Shower Rooms located on Clairmount and Dunlop were missing a shower grab bar on the adjacent wall (all rooms only had grab bar on the faucet side of wall)
- Spa Rooms located on Clairmont, Perry, Dryden were missing a shower grab bar on the adjacent wall, (all rooms only had grab bar on faucet side of wall)

The AGM indicated on October 19, 2015, that she would have maintenance personnel install the required shower grab bars.

As of October 23, 2015, five of the eight resident shower and spa rooms did not have the required shower grab bars in place to ensure resident safety. [s. 14.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following was observed during the dates of October 13-16 and October 19, 2015:

- Carpets – observed to have dark staining visible throughout areas on Clairmont, Dunlop, Dryden and Perry neighbourhood hallways; areas of carpet staining were more visible outside of tub/shower rooms and utility room. The carpeting in the Perry fireplace lounge was also noted to have dark staining in front of a wing back chair during the above dates.

- Flooring – tiled flooring in tub/shower rooms were observed to have dark staining visible between floor tiles in Clairmont and Perry neighbourhoods. The washroom floor in a resident's room was noted to be sticky.

- Toilets – dark staining visible at base of toilet and flooring in a resident washroom; in tub/shower room on Clairmont, and Perry and in communal washrooms on Perry.

PCA #111 indicated the floor in resident washroom is often sticky as the resident is often incontinent on the floor.
Housekeeping Aide #134 indicated that stains around toilet bases and floor are not removed by daily cleaning and may need more scrubbing.

The AGM indicated (to the inspector) the following:
- awareness of the carpets being stained, but attributed the staining to everyday wear and tear. she further indicated carpets are cleaned monthly and should be spot cleaned

by maintenance whenever staining is noted.
- toilets and flooring in resident rooms and common areas are to be cleaned daily and that there is no reason for stains around toilet bases.
- the tiled floors in tub and shower rooms had just been freshly grouted and that the staining could be due to residual application of the grout; would have maintenance look at the floors.

The AGM indicated (to the inspector) the expectation is the home should be clean and sanitary at all times. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of October 13, through to October 16, 2015:

- Flooring – the laminate flooring located in resident washrooms were noted to be split along the seam; across the floor and extended beside and along the area nearby the toilet. Flooring issues were identified in resident washrooms on Clairmont and Dunlop and in resident washrooms located near activity room / main street. Sub-flooring was visible underneath the split flooring.

- Dining Room Flooring – pulling away from wall in Perry dining room; sub-flooring with build- up of dust and debris visible.

- Walls – scuffed , gouged, chipped, paint missing or damaged (steel corner bead or dry wall exposed) – resident rooms in Clairmont, Dunlop and Perry; communal resident washrooms on Dunlop, Dryden and Perry, Dryden spa room, wall outside of Perry shower room, Perry activity room and areas throughout resident hallways on Perry.

- Wall Guard – was observed loose in a resident room located on Clairmont.

- Tiles – the wall tiling on spa and shower room walls on Perry, Dryden and Clairmont neighbourhood were noted to be chipped, cracked and or missing; the areas identified were jagged and sharp and posed a potential hazard to residents.

- Threshold Missing – transition piece (on flooring) leading from resident room into

washroom was missing in rooms on Clairmont, Dunlop and Perry.

-Counter-top Vanity – laminate along edges or sides of the counter-top vanity (sink cupboard) in resident room on Clairmont and in dining areas located on Perry, Dunlop – particle board (porous in nature) was visible where the laminate surround was missing.

- Overhead Light – encasement surrounding lighting encasement (over shower) was loose and hanging from ceiling in Dryden spa room.

Interviews with PCAs, Registered Nursing Staff and Housekeeping staff all indicated (to the inspector) if they notice areas within the resident home areas needing repair they would alert maintenance using the maintenance electronic requisition.

The AGM indicated (to the inspector) awareness of the following:
- Floors – seams split in washrooms or pulling from the walls (in Perry dining room)and that this was the result of a building flaw and that no plans were currently in place for repairs and or replacement.
- Tiles – AGM indicated (to the inspector) that she was aware of the chipped, cracked or missing wall tiles and that a contractor was coming to fix them October 19, 2015. (Note: as of October 22, 2015, tiles remained an outstanding maintenance deficiency)

The AGM reviewed electronic maintenance requisitions, with inspector, for the period of October 01 through to October 19, 2015 and indicated the above identified maintenance deficiencies (walls, wall guards, over-head light, counter-top vanity) were not noted by the home's staff as needing repair.

She indicated it would be an expectation that all staff utilize the electronic Maintenance Requisitions to alert maintenance (and herself) of needed repairs to the home, furnishings or equipment.

The Environmental Services Manager position has been vacant since approximately end of August 2015; the AGM is currently managing this department. [s. 15. (2) (c)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that it's policy "Prevention of Abuse in Long Term Care" Tab 04-06 was complied with.

The home's policy, Prevention of Abuse in Long-Term Care (#04-06) indicates that all team members are required to report any suspicions, incidents or allegations of abuse immediately and to follow Section 24 of the Long Term-Care Homes Act.

The policy directs that in situations involving team member (staff) to resident abuse the following action is to be taken:

Team Member will:
- Immediately separate resident from the alleged offender
- Call the police
- Team member who is close to the resident stay with the resident and provide comfort and reassurance to the resident
- Follow mandatory reporting requirements (Section 24)

GM, DOC, Neighbourhood Coordinator, Designate or On Call Manager will:
- Once notified of a suspected, alleged or witnessed abuse, confirm that the resident is safe and reassurance is being provided; if sexual or physical abuse occurred, call Medical Director and request a medical report with an opinion as to the probable cause of the injury; notification as soon as possible
- Continue to support the resident by a team member with a good relationship with the resident
- Call police immediately, if a sexual, physical offense or a theft has taken place.

The policy further indicates, that given that an incident of abuse maybe very traumatic for the Resident involved, the following resources and supports will be made available (list includes, but not limited to), all necessary medical treatment, support in the form of

regular visits from the chaplain, social worker through CCAC (community care access centre), external counselling.

On October 15, 2015 during stage 1 of the RQI, resident #026 reported an allegation of staff to resident physical abuse to the inspector.

On October 15, 2015 during an interview RPN #115 indicated the resident has in the past expressed being hurt by staff and this had been documented. A progress note was provided to the inspector that indicated the resident has told staff that he/she has been physically abused by a staff member and co- resident.

On October 15,2015 during the interview with RPN #115 indicated she had not reported the incident to her supervisor. RPN #115 informed inspector that abuse education had been provided annually.

The incident documented by RPN #115 describing an allegation of physical abuse towards resident #026 by staff and the staff member failed to report the incident to the supervisor as per the home's policy.

The reported allegation of staff to resident physical abuse by resident #026 to inspector #194 on October 15, 2015 has been brought forward to management at the home for investigation. [s. 20. (1)]

2. Related to Intake #O-001641-15, for Resident #022:

Under O. Reg. 79/10, s. 2. (1) sexual abuse is defined as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member".

A CIR was submitted by the home on an identified date, regarding an allegation of sexual abuse; as per the CIR, the alleged sexual abuse was said to have occurred 6 or 7 days earlier.

According to the CIR, details of the incident are as follows:
- Resident #022's SDM reported to the AGM, the resident had told his/her family that a few days ago, he/she was inappropriately touched.

The AGM indicated (to the inspector) resident #022's SDM had reported the allegation of

sexual abuse to her on an identified date.

A review of progress notes, for a specific period, interviews with the AGM, DOC, attending Physician and Family #048 provide the following: The licensee failed to comply with their policy, "Prevention of Abuse in Long-Term Care", as evidenced by the following:
- Reporting to the Director: Alleged sexual abuse was reported to the AGM on an identified date and not reported to the Director (Ministry of Health and Long-Term Care) until four days later
– AGM indicated (to the inspector) that she felt the reporting of alleged sexual abuse could wait till a later date, as it was thought the sexual abuse incident did not happen because resident #022 is cognitively impaired, and was a poor historian.
- Police Notification: An allegation of sexual abuse was not reported to the police by the AGM until three days later. The AGM indicated (to the inspector) the incident of alleged sexual abuse was not reported on the same day, as it was felt by herself the allegation was untrue as resident #022 is cognitively impaired and the staff member accused was an exemplary employee.

The AGM indicated (to the inspector) the actions described by resident #022 would be considered sexual abuse, but in this incident, she felt the allegation was unfounded and could wait to be reported.
- Physician Notification: alleged sexual abuse was not reported to the Medical Director until three days later – the AGM indicated (to the inspector) the delay in reporting to the Medical Director was because, it was felt incident of alleged sexual abuse did not happen.
- Assessment of resident: there is no evidence in the progress notes , or in the home's investigation of the incident that resident #022 was assessed for any injuries on the date the alleged incident was reported or dates following the allegation. The Medical Director indicated (to the inspector) the incident alleging sexual abuse was not reported to him.
- Provision of Support to the Resident: the AGM and DOC indicated the resident's SDM was contacted four days after the alleged incident and told that it was felt the allegation of sexual abuse did not happen and that the resident "was in a safe place".
There is no further indication in the progress notes, or in speaking with AGM, DOC and Attending Physician that resident #022 was provided support following the alleged incident of sexual abuse.

The AGM indicated it is an expectation that the home's policies are followed. [s. 20. (1)]

3. Related Intake #O-002296-15, for Resident #044:

The home's policy, Prevention of Abuse in Long-Term Care (#04-06), provides the definition of sexual abuse as "any non-consensual touching, behaviour, remarks of a sexual nature, or sexual exploitation directed towards a resident by a person other the licensee or team member. The policy directs that a team member, who is aware of the abuse, will separate the resident from the alleged offender, or if not possible remove the offender from the resident.

The policy, further directs if a criminal offence has taken place (e.g. sexual) the police are to be immediately called.
Resident #044 voiced concerns that resident #045 was continuously disruptive during the night and exhibiting inappropriate responsive behaviours. Resident #044 indicated these concerns were voiced to staff members (including management) but was told by the staff nothing could be done.

A review of progress notes for a two month period, confirmed the information provided by Resident #044. On two occasions Resident #044 slept in the lounge due to sleep disruptions and being upset with resident #045's responsive behaviours.

The home's policy, Prevention of Abuse in Long-Term Care, was not complied with by the following:
- Progress notes details twenty occasions (over a 2 month period) where resident #044 was inappropriately touched by resident #045. There is no documented evidence that the Director was notified of the inappropriate responsive behaviours, despite concerns voiced by resident #044.
- Neighbourhood Coordinator, indicated (to the inspector) some awareness of Resident #044's concerns , but explained that she was not aware of the frequency; she indicated that registered nursing staff should have notified her or the on-call manager of the concerns of Resident #044.
- there is no indication the police were notified of the inappropriate responsive behaviours.

The GM indicated the expectation is the home's policies are to be followed.
A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_396103_0043, which included a written notification specific to LTCHA, 2007, s. 20 (1) (b); the incident involving this resident was prior to the compliance due date of September 01, 2015. No further action will be taken. [s. 20. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

Regarding log #O-002046-15 related to Resident #043

On an identified date, the licensee received a written complaint from a family member expressing concerns related to the admission of a resident with an infectious disease to resident #043's room. The complaint also indicated that the home was not providing infection control practices to manage the issue.

The AGM has confirmed that the complaint letter was not provided to the Director until eight days after the letter was received by the home. [s. 22. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specific to:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Intake #O-001641-15, for Resident #022

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A CIR was submitted by the home on an identified date, regarding an allegation of sexual abuse; as per the CIR, the alleged abuse was said to have occurred 6 or 7 days earlier.

According to the CIR, details of the incident are as follows:
-Resident #022's SDM reported to the AGM that he/she was inappropriately touched. The resident identified PCA #117 as the staff member involved in this incident.

The AGM indicated (to the inspector) that resident #022's SDM had reported the allegation of abuse to her on an identified date. She further indicated that she is aware that any alleged, suspected or witnessed abuse is to be immediately reported to the Director (Ministry of Health and Long-term Care), but "it was felt by herself and the Neighbourhood Coordinator the abuse did not occur, as resident #022 was cognitively impaired, and was a poor historian; and further commented PCA #117 was an exemplary employee.

The AGM acknowledged the alleged sexual abuse was not immediately reported to the Director. [s. 24. (1)]

2. On an identified date staff witnessed an incident of physical abuse between resident #058 and resident #059 at the nursing station. There was an altercation between the two resident and one of the resident sustained a minor injury.

A CIR was initiated and the report was provided to the Director 9 days after the incident.

During interview with Inspector #194, the GM indicated that no immediate notification to the Director was made. [s. 24. (1)]

3. Regarding Resident # 053

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, emotional abuse is defined as " any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident".

On an identified date resident #053 reported to the DOC that a staff member had been emotional abusive toward him/her and the resident was frightened and did not want this staff member to provide care any longer.

During the licensee's investigation into the allegation it was determined the incident had occurred as mentioned by the resident. RN #163 had been informed of the incident by the RPN on duty. No staff member came forward and informed the management team of the incident. Resident #058 reported the incident to the DOC the following morning. [s. 24. (1)]

4. Related Intake #O-002296-15, for Resident #044:

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #044 indicated (to the inspector) that he/she voiced complaints to the nursing staff, that he/she was upset that resident #045 was being disruptive during the night and exhibiting inappropriate responsive behaviours. Resident #044 indicated these concerns were reported to all staff.

A review of progress notes for a two month period, confirmed the information provided by resident # 044 regarding the actions of resident #045.

The Neighbourhood Coordinator and the AGM indicated (to the inspector) being aware of resident #044 concerns. They both indicated the Director was not notified of the allegation of sexual abuse of resident #044 by resident #045, as they felt the incident was not sexual in nature

As of October 21, 2015, the home has yet to submit a CIR relating to alleged abuse of resident #044.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_396103_0043, which included a written notification specific to LTCHA, 2007, s. 24(1); the incident involving this resident was prior to the compliance due date of September 01, 2015. No further action will be taken. (554) [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Intake #O-002916-15, for Resident #022:

The licensee failed to comply with O. Reg. 79/10, s. 50 (2) (b) (i), by not ensuring the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home's policy, Wound and Skin Care (#04-78) indicates the goal of the home is to promote optimum skin conditions of its residents. A complete skin assessment will be completed on admission, on return from hospital, after a leave of greater than 24 hours, quarterly and when there is a change in the resident's health status that affects the skin integrity. The policy directs that any redness, bruises, open areas, rashes will be reported to the Wound Care Nurse or designate using the Skin Assessments Concerns Form; the wound care nurse or designate will complete the skin/wound assessment tool of the areas reported, which will continued to be completed on a weekly basis by the registered nursing staff in the neighbourhood.

Resident #022's clinical health record for a nine month period indicated the resident had altered skin integrity and it was first noted by registered nursing staff on an identified

date. Progress notes, during the same time period, indicated resident #022 complained of discomfort.

- Quarterly Skin Assessments were completed by registered nursing staff over a six month period.

Neighbourhood Coordinator, (lead for the Skin and Wound Care Team), indicated (to the inspector), she was aware that resident #022 had altered skin integrity, but was not aware that it was still an issue until recently ; Neighbourhood Coordinator indicated that she had not received any documentation (Skin Assessment Concerns Form) from the registered nursing staff and that she herself had not seen the resident's skin.

Neighbourhood Coordinator indicated that skin assessments should have been completed, using the home's electronic skin assessment tool on dates when resident #022 was exhibiting altered skin integrity as well as weekly progress notes detailing the skin issue and monitoring by registered nursing staff.

A review of progress notes and skin assessments for resident #022 failed to provide evidence that skin assessments were completed when resident exhibited altered skin integrity nor as per the home's policy. [s. 50. (2) (b) (i)]

2. Related to Intake #O-002916-15, for Resident #022:

The licensee failed to comply with O. Reg. 79/10, s. 50 (2) (b) (ii), by not ensuring the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #022's SDM, indicated (to the inspector) the resident had ongoing altered skin integrity which they felt was not being properly treated, despite the family voicing their concerns.

Progress Notes for a nine moth period, detailed the condition of the resident's skin, dermatology referral and any treatment provided.

The MAR and Treatment Observation Records (TAR) reviewed for this period, showed that over a nine month period, the medicated treatments and PRN medication was not being administered as prescribed.

The Neighbourhood Coordinator, and RPN #110 indicated (to the inspector) that PCAs have been delegated by the registered staff to administer medicated treatment to residents during morning and bedtime care.

PCAs interviewed indicated (to the inspector) registered nursing staff would direct PCAs to apply medicated treatment to residents in shift report and provide PCA with medicated treatments only as needed; PCA indicated (to the inspector) that if a medicated treatment was administered the PCA would sign for treatment being administered in the TAR record.

Attending Physician, for resident #022 indicated (to the inspector) that it would be an expectation that registered nursing staff would administer medicated treatment, as well as PRN medication to resident's altered skin integrity or for complaints of discomfort as per his orders. The Physician indicated he had documented in his progress notes, as well as discussed his concerns with the DOC, that medications (oral as well as medicated treatments) as per his orders were not being administered to resident #022.

Neighbourhood Coordinator,indicated (to the inspector) the expectation is registered nursing staff (and/or PCAs) follow physician's orders specific to treatment and or interventions for resident's exhibiting altered skin integrity. Neighbourhood Coordinator further indicated, that if the treatment or intervention was not documented in the progress notes,on the MAR or TAR it would be assumed that care was not provided.

A review of progress notes, medication and treatment administration records, for the nine month period , failed to provide documented evidence that resident #022 consistently received treatment and interventions to reduce or relieve discomfort, and or to promote healing when he was exhibiting altered skin integrity (e.g. rash). [s. 50. (2) (b) (ii)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a response in writing was made within 10 days of receiving Family Council advice related to concerns or recommendation.

A review of the Family Council minutes on an identified date revealed the following concerns:
- residents on a specific neighbourhood had concerns about dining
- interventions to create a calmer environment and ongoing concerns with housekeeping where (sticky floors, bathrooms not clean, no dusting in residents rooms).

Review of the minutes on an identified date indicated concern related to limited programming on the weekend.

During an interview with the AGM, she confirmed a written response was not provided to the Family Council within 10 days of receiving the above identified concerns. [s. 60. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.
s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council.

During the initial tour of the home on October 13, 2015, the inspector observed the following information was not posted in the home
- the long term care policy on Zero tolerance of abuse
- the most recent Family Council Meeting minutes

Interview with the DOC confirmed that the above identified items were not posted in the home. [s. 79. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The home's policy, Odour Control (#03-05) indicates that offensive odours will be prevented where possible and to identify and address incidents of offensive odours that cannot be prevented; offensive odours will be addressed proactively by removing soiled linens as soon as possible, removing odour causing garbage, using automatic

deodorizers and or odour eliminators in high odour areas, providing odour control products to team members to use when necessary and use of automatic / regular use of exhaust fans throughout the home.

During the dates of October 13, 14, 15, 16 and 19, 2015, the following was noted:
- resident's room, located on a specific neighbourhood , was noted to have a pervasive malodour; the odour was noticeable upon entering the resident’s room and was increasingly more noticeable as the inspector went further in this resident room. The pervasive odour smelt strongly like urine.
- The washroom in a resident's room located on the same neighbourhood, was noted to have a strong urine like odour; the malodour grew increasingly stronger as the inspector walked towards the toilet. It was further noted the flooring in this washroom was ‘wet’ surrounding toilet on October 14 and October 15, 2015.

Additional Observations:
- Communal washroom, located on an identified neighbourhood (near spa room, upon entry to neighbourhood) was noted to have a malodour; this observation was made October 14, 15 and 16, 2015.

PCA #111 and RPN #110 both indicated that housekeeping staff are responsible for odour control products (e.g. disinfectant sprays); PCA and RPN indicated they do not carry odour eliminator sprays on their care carts or medication carts.

Housekeeping Aide #134 indicated (to inspector) that a cleaning solution is used to clean resident rooms and washrooms on a daily basis, and can be used to spray on "odorous " areas as needed; Housekeeping Aide #134 indicated the housekeeping department does use an additional odour spray, but she is unable to use this spray and uses alternative solutions.

The AGM indicated it would be an expectation that resident rooms and neighbourhood areas would be free of lingering odours. [s. 87. (2) (d)]

WN #19: 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. Related to Intake #O-001641-15, for Resident #022:

The licensee failed to comply with O. Reg. 79/10, s. 98, by not ensuring that the appropriate police force was 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.

An alleged incident of sexual abuse was reported by the SDM of resident #022 to the AGM on an identified date.

The AGM, indicated (to the inspector) that resident #022's SDM reported on an identified date, the resident had been inappropriately touched by staff.

The AGM indicated (to the inspector) these actions would be seen as inappropriate and would be seen as sexual abuse.

The AGM indicated the allegation of abuse was not reported to the police immediately as the incident was not believed to have occurred.

AGM indicated that she did contact the police on an identified date, and indicated being told by the Durham Regional Police, that the family of resident #022 had already reported the abuse allegation. [s. 98.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 100, by not ensuring the written complaint procedures in place incorporates the requirements set out in section 101 for dealing with complaints.

The home's policy, Resident and Family Concerns (#11-21) fails to incorporate the requirements set out in O. Reg. 79/10, section 101 for dealing with complaints as evidenced by the following:

- Under section 101, where a complaint alleges harm or risk of harm, the investigation shall be commenced immediately. The home's policy speaks to "if a complaint alleges harm, the investigation will commence immediately".

- Under section 101 (1) – every licensee shall ensure that every verbal or written complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home is dealt with as follows:

1) the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within ten business day or the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more resident, the investigation shall commence immediately;

2) For those complaints that cannot be investigated and resolved within ten business days, an acknowledgment of the receipt of the complaint shall be provided within ten business days of the receipt of the complaint including the date, by which the complainant can reasonably expect a resolution, and a follow up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The home's policy, Resident and Family Concerns, speaks to "the Neighbourhood

Coordinator or designate will contact the family member or resident on the same day to clarify the concern and acknowledge that the concern has been received. The Neighbourhood Coordinator will contact the family member or resident directly within five working days of the commencement of the investigation, unless the complainant alleges harm, to discuss the results of the investigation and remedial action if any. If the family member or resident is not satisfied they will be encouraged to refer the matter to the General Manager which will be responded to in writing within ten days".

- Under section 101 (3) – a response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

The home's policy, Resident and Family Concerns, does not meet the requirements as specified under section 101 (3) as it states "if the family member or resident wishes to be specifically informed of when the follow-up actions are completed, the Neighbourhood Coordinator will provide a written confirmation". [s. 100.]

Issued on this 11th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA FRANCIS-ALLEN (552), CHANTAL LAFRENIERE (194), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), KELLY BURNS (554)
Inspection No. / No de l'inspection :	2015_291552_0024
Log No. / Registre no:	O-002656-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 15, 2016
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF TAUNTON MILLS 3800 Brock Street North, WHITBY, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jillian Heaver

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To OAKWOOD RETIREMENT COMMUNITIES INC., 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: 2015_396103_0043, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that:
1. An effective communication protocol related to abuse is established and implemented. The communication protocol will ensure that:
a) The Director is immediately notified of all incidents of abuse at the home (as noted in WN #14
b) Further education to staff to understand what constitutes abuse in a resident to resident altercation

2. A monitoring process is in place to assess the effectiveness of the communication protocols between front line, registered staff and management including a method:
- whereby the DOC and/or delegate is reviewing all communication between frontline and registered staff to determine if any abuse has occurred in the home
- whereby appropriate and timely follow up is completed by DOC and/or designate for any incident of abuse documented or reported, ensuring that all legislative requirements have been fulfilled
- monthly analysis of all incidents of resident abuse is completed to identify and address any deficiencies.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Under O. Reg 79/10 s. 2(1) Physical abuse definition:
-- (c) "the use of physical force by a resident that causes physical injury to another resident"

A review of the home's critical incident report (CIR) log for incidences occurring after September 1, 2015 was conducted. The following information was found:

Review of the CIR describing that Resident # 059 hit Resident #058. Resident #058 sustained a minor injury. The incident occurred on an identified date, the Director was notified 9 days after the incident.

Regarding Resident #053

Under O. Reg 79/10 s. 2(1) Emotional abuse definition :
- (a)" any threatening insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident ".

The review of a CIR of an alleged staff to resident emotional abuse that occurred on an identified date was submitted to the Director three days later.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19 was issued during inspection #2015_396103_0043 which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1), with a compliance date of September 1, 2015

The decision to issue a Compliance Order (CO #001) for the second time is based on two separate occasions on September 1 & October 7, 2015 where under the legislative requirements, immediate notification to the Director was to be completed and the licensee failed to report. (194) (194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 15th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria Francis-Allen

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