Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017;	2017_687607_0016 (A1)	010230-17, 013620-17, 013871-17, 014347-17, 014929-17, 018914-17	Critical Incident System

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The LTC home requested CO# 002 compliance date be changed from November 15, 2017 to December 15, 2017.

Issued on this 29 day of November 2017 (A1)

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

Original report signed by the inspector.

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JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 21, 22, 23 and 24, 2017. Off site interviews were also conducted September 7 and 8, 2017.

During the Critical Incident Inspection the following intakes were inspected Log #'s 010230-17, 013620-17, 013871-17, 014347-17, 014929-17, 018914-17.

Summary of Intakes log #'s :

1) 010230-17and 018914-17: regarding alleged resident to resident physical abuse.

2) 014929-17, 013871-17, 013620-17, 014347-17: regarding alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Neighbourhood Coordinator, Registered Nurses (RN) Registered Practical Nurses (RPN), Personal Care Attendants (PCA) and residents.

During the course of the inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed training records, investigation notes and applicable policies.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

8 WN(s)
1 VPC(s)
2 CO(s)
2 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act "physical abuse" means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident; "emotional abuse" means, any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Related to Log #018914-17 involving resident #006 and #007:

A Critical Incident Report (CIR) was submitted to the on an identified date and time, for an incident of witnessed resident to resident physical abuse that occurred on an identified date and time involving resident #006 and #007 that resulted in resident #006 sustaining an injury.

A review of the clinical health record indicated that resident #006 and #007 has diagnoses that includes cognitive impairments.

A review of the progress notes for resident #007 for a five month time period, indicated there were additional incidents of resident to resident physical abuse/aggression and/or emotional abuse by resident #007 that were directed towards other residents, that were not investigated, had no documented evidence to indicate the recipient resident of the alleged abuse was assessed for injury or distress, reported to the Substitute Decision Makers (SDM), reported to the Director, or the police in relation to responsive behaviours (Refer to WN # 2 for

details).

During an interview, PCA #113 indicated that resident #007 exhibits several identified responsive behaviours that includes targeting resident #006. PCA #113 indicated that when resident #007 exhibits these behaviours, the staff would redirect other residents from the resident, as resident #007 was difficult to redirect, as well as the staff would perform increase observations of resident #007.

During an interview, RPN #101 indicated that resident #007 can appreciate the consequences of his/her actions, in the moment, and further indicated that when the resident exhibited physical and emotional behaviours directed towards other resident's staff would redirect the resident.

2. Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means, (b) 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.

Related to two Intake Log #'s 013620-17 and 014347-17 involving resident #001 and #002; and one Intake Log # 014929-17 involving resident #002 and #003:

A review of the clinical health records for resident #001, #002, #003, #004 and #008 indicated the residents has diagnoses that includes cognitive impairments.

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time for a incident of a witnessed resident to resident sexual abuse involving resident #001 and #002.

A second Critical Incident Report was submitted to the Director on an identified date and time for an incident of a witnessed resident to resident sexual abuse involving resident #001 and #002.

A third Critical Incident Report (CIR) was submitted to the Director on an identified date and time for a witnessed incident of a resident to resident sexual abuse involving resident #002 and #003.

In addition to the above Critical Incident Reports, a review of the progress notes for resident #002, indicated there were several incidents of suspected and or witnessed sexual responsive behaviours involving resident #001, #003, #004 and

#008, that were not investigated, had no documented evidence to indicate the recipient resident of the alleged sexual abuse was assessed for capacity at the time of each incident to determine consent, or to indicate the incidents were reported to the Substitute Decision Maker (SDMs), the Director, or the police as follows:

There were several incidents of sexual responsive behaviours involving resident #008 and resident #002 over a two month period and one on another an identified date, involving resident #002 and an unidentified resident. The plan of care was not updated to include interventions related to the residents consenting to sexual responsive behaviours until two month after the initial incident. The Director was not notified of any of the incidents within the two months period the incidents occurred, or after. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent.

There were several incidents of resident to resident sexual responsive behaviours involving resident #003 and #002 on three identified dates. Of the incidents identified, only one was reported to the Director. During one of the incidents, there was no nursing staff present as per plan of care to provide increase monitoring for resident #003. In addition, there was one incident of sexual responsive behaviours involving resident #003 and #004 and one involving an unidentified resident. (Refer to WN #2 for details)

There were also two incidents of resident to resident's sexual responsive behaviours involving resident #001 and #002 . The plan of care for resident #001 was not updated to include interventions related to the residents consenting to sexual responsive behaviours until a month later. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent. (Refer to WN #2 for details)

A review of the written plan of care for resident #002 and #001, indicated there were several interventions that were put in place two weeks prior to the inspection, related sexual responsive behaviours.

A review of resident #003's written plan of care indicated there several identified interventions related to responsive behaviours that were put in place a six weeks prior to the inspection. Further review of resident #003's written plan failed to locate

interventions related to consent to sexual responsive behaviours.

A review of the written care plan for resident #001 that was in place on or after the above identified incidents and currently in place, failed to identify interventions related to resident #001's sexual responsive behaviours and how staff were to manage these behaviours.

During an interview, PCA #109 indicated resident #002 exhibited sexual responsive behaviours and further indicated these behaviours were directed towards resident #003 and #008. The PCA indicated all three residents seek each other out in a sexual manner.

During interviews, RPN #111 and #108 both indicated that resident #001 and #002 are cognitively impaired and were not able to consent to sexual responsive behaviours. Registered Practical Nurse #108 indicated that resident #002 was not capable of consenting to sexual activities and further indicated that both resident #003 and #008 are cognitively well to consent to sexual activities.

During an interview, the AGM indicated that resident #002 is deemed incapable of consenting, and cannot consent to sexual activities. The AGM indicated that a capacity assessment was not completed on resident #001, #002, #003, #004 and #008 to determine if the residents were able to consent to sexual activities at the time of each incident. The AGM indicated that the licensee's expectation is when residents' exhibits sexual responsive behaviours, the PCAs are to report the behaviour to the Nurse in charge of the unit, who in turn report this to the RN, and the RN would contact the on call Manager.

During an interview, Physician #118, indicated that resident #002 is competent, but was unable to comment as to whether or not the resident is able to consent to sexual activity, as he/she did not complete an assessment on the resident to determine the resident's capability to consent to sexual activity.

During interviews, the DNC and the AGM both indicated that some of the above specified incidents were not reported to the SDM's, the Director or the Police, as the incidents were not reported by the front line staff to the DNC.

The licensee failed to ensure that when there was actual sexual abuse involving resident #001, #002, #003, #004, and #008 the recipient residents were protected. The licensee also failed to ensure that when there was actual physical/emotional

abuse directed by resident #007 towards resident #005, #006, #009 and #010 the recipient residents were protected.

The severity of this non-compliance is potential harm and the scope is pattern. The homes compliance history indicated LTCHA, 2007, s.19 (1) was issued as a Compliance Order, during a Resident Quality Inspection on October 9, 2015, (inspection # 2015_291552_0024). In addition, a Compliance Order related s. 19 (1) was also issued during a Critical Incident Inspection on July 2, 2015 (Inspection # 2015_396103_0043). There was evidence of ongoing sexual responsive behaviours involving resident #001, #002, #003, #004 and #008 that would indicate that these residents were not being protected from ongoing sexual abuse as evidence that the licensee submitted three Critical Incident Reports to the Director. [s. 19. (1)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; and strategies are developed and implemented to respond to these behaviours, where possible and actions are taken to respond to the needs of the resident, including reassessments and interventions and that the resident's responses to interventions are documented.

Related to Intake Log #'s 014929-17 involving resident #002 and #003, Log #013871-17 involving resident #003 and #004, and Log #013620-17 involving resident #001 and #002:

A review of the clinical health records for resident #001, 002, #003, #004 and #008 indicated that the residents had diagnoses that includes Cognitive Impairments.

A review of the progress notes for resident #001, #002, #003, #004, and #008 over a five month time period, indicated that there were ongoing incidents of demonstrated sexual responsive behaviours by the residents that were directed towards each other as follows:

Related to resident #002 and #008:

There were five incidents of sexual responsive behaviours involving resident #008 and resident #002 between a two month time period and another one on an identified date, involving resident #002 and an unidentified resident.

Related to resident #002, #003 and #004:

There were four incidents of resident to resident sexual responsive behaviours involving resident #003 and #002. Of the five incidents, only one was reported to the Director. During one of the incidents there was no nursing staff present to provide increase monitoring for resident #003. In addition, there was one incident of sexual responsive behaviours involving resident #003 and #004 on an identified date and one on another identified date, involving an unidentified resident.

Related to resident #001 and #002:

There were also four incidents of resident to resident's sexual responsive behaviours involving resident #001 and #002. The plan of care for resident #001 was not updated to include interventions related to the residents consenting to sexual responsive behaviours until two months later. The Director was notified of only two of the incidents. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent.

A review of the written care plan for resident #001 that was in place on and after the above identified incidents, failed to identify any interventions or triggers related to resident #001's sexual responsive behaviours and how staff were to manage these behaviours.

A review of the written care plan for resident #004 that was in place on or prior to the inspection, and currently in place, failed to identify interventions or triggers related to resident #004's sexual responsive behaviours and how staff were to manage these behaviours.

A review of the written care plan for resident #002 and #008 indicated that both residents had several interventions in place related to sexual responsive behaviours. Further review of the written plan of care for resident #002 and #008 failed to locate documented interventions related to the resident triggers related to sexual responsive behaviours.

During interviews, RPNs #105, #116, PCAs #117 and #109, all indicated that resident #002 and #008 exhibited sexual responsive behaviours directed towards each other and indicated that when the residents exhibited these behaviours staff

would intervene and redirect resident.

During an interview, RPN #105 indicated not being aware of what some of the wording meant in relation to interventions in both residents care plans (#002 and #008). There were no documented interventions in the written plan of care to direct staff as to whether the residents were allowed touch each other or whether staff should be redirecting both residents, even though the interventions indicated both residents were consenting to sexual expressions.

A review of the clinical health records for resident #002 and #008 failed to locate documented evidence that either residents were a part of the (Personal Expression Program Layered Natured Framework (PERTH) program, (a behavioural assessment tool).

During an interview, the Neighbourhood Coordinator #117 indicated, that each unit had binders with referral related to the PERTH program, and indicated that any registered staff can refer a resident to the PERTH program. The Neighbourhood Coordinator #117 indicated that referral was not received for resident #002 or #008 related to the resident's behaviours and further indicated that both residents were not a part of the PERTH program and not being looked at in relation to their behaviours and triggers.

During an interview, an external Geriatric Consultant indicated that he/she believes resident #003 is unable to consent to sexual activities and feels the resident is cognitively impaired. The Consultant also indicated not receiving a referral for resident #002 or #008 in relation to their ongoing sexual responsive behaviours.

During an interview, the DNC indicated that both resident #008 and #002 were consenting to sexual expressions, and further indicated that a capacity assessment was not completed on either residents to determine if they had the capacity to consent to sexual activities after each identified incident.The DNC indicated the care plan does not provide clear directions to staff and indicated that both resident #002 and #008 are consenting to a sexual relationship, but there is a question of capability. The DNC indicated that the sexual expressions resident #002 and #008 displayed towards each other were ethical in nature and indicated he/she would have to consult with a corporate consultant to see how best to address the concerns. The DNC also indicated that resident #002 was moved more than once to different units during the above identified incidents and the home was thinking of performing another move, as the resident was now exhibiting these sexual

responsive behaviours towards resident #008.

The strategy of referring resident #002 and #008 to the PERTH program or external geriatric consult was not considered by the licensee. Resident #002's written plan of care failed to identify triggers, when the resident exhibited ongoing sexual responsive behaviours involving three other residents (#001, #003 and #008). The written care plan for resident #004 that was in place on and after the above identified incidents and currently in place, failed to identify interventions or triggers related to resident #004's sexual responsive behaviours and how staff were to manage these behaviours. The Plan of care for resident #001 and #004 was not updated to include triggers identified in relation to both resident's sexual responsive behaviour. The licensee also failed to ensure that when actions were taken to respond to the needs of resident #002 including reassessment and interventions, that the resident response to those interventions were documented, as resident #002 was moved more than once to different units during the above identified incidents of sexual responsive behaviours, and the home was thinking of performing another move to another unit. The licensee also failed to ensure that there was documented evidence of how resident #002 responded to these interventions and that other strategies were considered in the revision of the plan of care. The licensee also failed to ensure that actions were taken to respond to the needs of the resident #002 and #008, including reassessments and interventions and that the resident's responses to interventions were documented, specifically related to resident #002 and #008 had ongoing sexual responsive behaviours and were not reassessed related to these behaviours.

2. Related to Log #018914-17 involving resident #006 and #007:

A Critical Incident Report was submitted to the Director on an identified date and time, for an incident of resident to resident physical abuse involving resident #006 and #007 that resulted in injury to resident #006.

A review of the clinical health records indicated that resident #007 had multiple diagnoses that includes Dementia. .

A review of resident #007's written plan of care related to responsive behaviours indicated the resident had several identified interventions in place.

During interviews, PCA #113 and RPN #101 both indicated that resident #007 exhibited responsive behaviours that were both verbal and physical in nature and

further indicated that the resident is territorial of his/her space and would target resident #006. PCA #113 indicated that when resident #007 exhibits these behaviours the staff would redirect other residents from the resident, as resident #007 is difficult to redirect, as well as the staff would perform increase observations of resident #007.

A review of the clinical health records for resident #007 indicated that a Behavioural Assessment Tool (Layered Natured Framework Discussion Notes) was completed 17 months prior to the inspection. This was completed before the escalation of responsive behaviours of verbal and physical aggression towards other residents. The layered framework identified several behaviours exhibited by the resident and one intervention related to medication changes. There was no documented evidence to indicate actions had been taken to prevent risk of injury or harm to other residents either in written care plan or in the Layered Natured Framework Discussion notes (a behavioural assessment tool) within the last 17 months or after the incidents identified nor were all triggers related to these behaviours identified.

During an telephone interview, the Director of Nursing Care indicated that resident #007 was a part of the Personal Expression Resource Team (PERTH) program, and had a Personal Expression Program Layered Natured Framework, (a behavioural assessment tool) currently in place.

During an interview, the Neighbourhood Coordinator #117 indicated, that each unit had binders with referral related to the PERTH program, and indicated that any registered staff can refer a resident to the PERTH program. The Neighbourhood Coordinator #117 indicated that a referral was received for resident #007, 17 months prior, and indicated that care plans are updated after each incident of resident's responsive behaviours. The Neighbourhood Coordinator #117 indicated there were no triggers identified in resident #007 written care plan related to the residents responsive behaviours.

A review of the progress notes for resident #007 for a six month time period, indicated resident #007 had several identified responsive behaviours in relation to verbal, emotional and physical abuse/aggression related to the resident's responsive behaviours.

The progress notes indicated, there were several incidents of resident to resident physical altercations and potentially harmful interactions involving resident #007

directed towards resident #006, #009, #010, #011 and an unidentified resident, one resulted in injury involving resident #007 and #006. There was no documented evidence that an interdisciplinary assessment was completed to identifying factors that could potentially trigger such altercations and interventions were not identified and or implemented until after the last CIR was submitted to the Director where resident #006 sustained an injury.

There was no intervention in the written plan of care of resident #006 to indicate how staff were to protect the resident from resident #007, considering interviews with staff and record review indicated resident #007 targets resident #006.

The licensee also failed to ensure that actions were taken to respond to the needs of the resident #007 and other residents, including reassessments and interventions and that the resident's responses to interventions were documented, specifically related to resident #007 had ongoing harmful interactive responsive behaviours that were directed at several residents and the resident was not reassessed related to these behaviours.

The severity of this non-compliance is both actual and potential harm and the scope is pattern. The home does have a history of non-compliance related to responsive behaviours that was issued as Voluntary Plan of Correction on October 9, 2015, during a Resident Quality Inspection. A compliance Order was warranted due to the scope and severity of identified incidents. [s. 53. (4)]

Additional Required Actions:

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

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Related to Intake Log #010230-17 related to resident #005:

A Critical Incident Report was submitted to the Director for an incident of alleged resident to resident physical abuse that occurred on an identified date and time involving resident #005 and #006 that resulted in an injury to resident #006.

A review of the written plan of care for resident #006 indicated the resident had a several interventions in place related to wandering behaviours.

A review of the progress notes for resident #006 indicated there were two incidents on two separate dates, where physical abuse was directed towards resident #006 by two separate residents (resident #005 and #007) that resulted in the resident #006 sustaining injuries.

A review of the written plan of care failed to set out the planned care for resident #006, specifically related to identified interventions related to safety risk and how to ensure resident #006 was safe. The written plan of care failed to indicate steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #006 and other residents (resident #005 and #007) by identifying and implementing interventions. [s. 6. (1) (a)]

2. The licensee has failed to ensure that care set out in the plan of care provided to resident #005 as specified in the plan.

Related to Log #010230-17 involving resident #005:

A Critical Incident Report was submitted to the Director on an identified date and time for an incident of alleged resident to resident physical abuse where resident #006 sustained an injury.

A review of the written plan of care for resident #005 indicated the resident had several identified interventions in place related to responsive behaviours.

On an identified date at three separate times, the Inspector observed resident #005 in bed asleep with no wander guard (yellow barrier strip) across the door.

During interviews, PCAs #100, #103 and RPN #101, all indicated that they have never seen a wander guard attached to resident #005's bedroom door.

During an interview, PCA #102, indicated resident #005 should have a wander guard attached to his/her room door.

During an interview, the AGM, indicated the expectation is that resident #005 should have a wander guard attached to the resident's door as this prevents other resident from wandering in resident #005's room.

The licensee has failed to ensure that care set out in the plan of care was provided to resident #005 as specified in the plan, specifically related to not ensuring a wander guard was attached to the residents door to prevent other residents from wandering in the resident's room. [s. 6. (7)]

3. Related to Intake Log #014929-17 involving resident #002 and #003:

A Critical Incident Report was submitted to the Director on an identified date and time for an incident of alleged resident to resident sexual abuse involving resident #003 that was directed towards resident #002.

During a telephone interview on an identified date, the DNC indicated that at the time of the above identified incident, resident #002 had interventions in place to have nursing staff to provide increase supervision of the resident, due to previous incidents of sexual responsive behaviours that were direct towards resident #002 by another male resident (#001). The DNC further indicated that the incident occurred at an identified time and the resident was to have nursing staff interventions in place for another two hours, but the nursing staff had to leave early that day, resulted in resident #003 exhibiting sexual responsive behaviours towards resident #002.

The licensee has failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan, as the supervision by a nursing staff was not provided on an identified date, for the entire shift as per plan of care. The care was not provided to resident #002 as per plan of care. [s. 6. (7)]

4. The licensee failed to ensure that the provision of the care was set out in the plan of care.

Related to Intake Log #010230-17 involving resident #005:

A Critical Incident Report was submitted to the Director on an identified date and time, for an incident of witnessed resident to resident physical abuse involving resident #005 and #006 that resulted in resident #006 sustaining an injury.

A review of resident #005's current plan of care and the written plan of care that was in place at the time of the incident, for resident #005 related to responsive behaviours indicated the resident had several interventions in place.

During interviews with Personal Care Attendants (PCA) #100, #102, #103 and Registered Practical Nurse (RPN) #101, all indicated that resident #005 was on increase monitoring documentation related to responsive behaviours, and this was documented using a Watch Tracker Form. Personal Care Attendants (PCA) #100, #102, #103 and RPN #101 all indicated, that they were not sure if this Watch Tracker Form was to be completed by the PCAs on every shift related to resident #005, and further indicated the completed documentation related to the Watch Tracker Form is kept in a binder by the nursing station. PCAs #100, #102, #103 and RPN #101 all indicated that resident #005 also had a nursing staff for increased observations on the an identified shift.

Further review of resident #005's written care plan failed to locate documentation for the resident related to staff completing a Watch Tracker Form for the resident.

A review of the Watch Tracker Forms for resident #005 located in a binder at the nursing station, indicated that the forms were completed on three identified dates, by the staff on the identified shift and on another two identified dates by staff on an identified shift. There was no documented evidence to indicate that Watch Tracker forms were being completed by the staff on all shifts on an ongoing basis.

During an interview, the AGM indicated that the expectation is staff should be completing the Watch Tracker Form for resident #005 on every shift and further indicated the interventions related to the Watch Tracker Form being completed should have been included in the written care plan for resident #005.

The licensee has failed to ensure that the provision of care was set out in the written plan of care for resident #005 was documented, specifically related to the written plan of care did not provide instructions to staff regarding the completion of a Watch Tracker Form and the frequency of this completion/documentation. [s. 6. (9) 1.]

5. The licensee failed to ensure that when the resident is reassessed, the plan of care was reviewed and revised when the resident's care needs change or when the care set out in the plan is no longer necessary.

Related to Log #010230-17 involving resident #005 and #006:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, for an incident of alleged resident to resident physical abuse involving resident 005 and #006.

On an identified date and time resident #006 was observed using a mobility device in an identified area.

A review of the written care plan for resident #006 that was in place at the time of the incident, and currently in place related to transfers and mobility, indicated the resident is independent with transferring; occasional needs assistance of one team member as well as the resident is independent with an identified mobility device.

During interviews, PCA #100 and RPN #101, both indicated that resident #006 previously used the mobility device identified in the written care plan, but no longer uses the device as the resident is assessed for another mobility device related to a recent fall. PCA #100 also indicated that resident #006 no longer transfers independently, but requires a mechanical device and the assist of two staff for transfers.

During an interview, the AGM indicated that the expectation is that staff are to update residents written plan of care when the resident ambulation status or care needs changes.

The licensee failed to ensure that when resident #006 was reassessed, the plan of care was reviewed and revised at any other time when the resident's care needs change or when the care set out in the plan was no longer necessary, specifically related to the resident mobility and transfer status. [s. 6. (10)]

6. Related to Intake Log #013620-17 involving resident #001 and #002:

A Critical Incident Report (CIR) was submitted to the Director for an incident of an alleged resident to resident sexual abuse involving resident #001 and #002.

A review of the progress notes for resident #001 indicated there were four incidents of witnessed resident to resident sexual abuse involving resident #001 and #002.

A review of the written care plan for resident #001 that was in place on or after the identified incidents and currently in place, failed to identify written interventions related to resident #001's sexual responsive behaviours and how staff were to manage these behaviours.

During an interview, RPN #111 indicated that if a resident was exhibiting sexual responsive behaviours, the home's expectation is that interventions are to be documented in the written care plan to address these behaviours. Registered Practical Nurse #111 reviewed the written care plan for resident #001 and indicated to the Inspector that interventions related to the resident sexual responsive behaviours were not documented in the written care plan until two days after the Inspector initiated the inspection, close to two months after the initial incident involving resident #001 and #002.

During an interview, the AGM indicated that the home's expectations is residents care plan should be updated when a resident care needs change.

The licensee has failed to ensure that resident #001's plan of care was reviewed and revised at any other time when the resident's care needs change, specifically related not including interventions in the resident written plan of care related to sexual responsive behaviours, until approximately two months after an initial incident involving resident #001 and #002. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident specifically related to resident #005; ensuring that care set out in the plan of care provided to resident #002 and #005 as specified in the plan and ensuring that when the resident is reassessed, the plan of care was reviewed and revised when the resident's care needs change or when the care set out in the plan is no longer necessary, specifically related to resident #005, #001 and #002, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

A review of the licensee Prevention of Abuse and Neglect policy #Tab 04-06 (Page 6/10) directs:

Any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and information upon which it is based to their immediate supervisor or any member of the leadership team:

2. Abuse of a resident by anyone or neglect of a resident by the Village or team member that resulted in harm or risk of harm to the resident.

Related to two Intake Log #'s 013620-17 and 014347-17) involving resident #001 and #002; and one Intake Log # 014929-17 involving resident #002 and #003:

There were 13 incidents of either suspected and/or witnessed incidents of sexual abuse involving resident #001, #002 #003 and #008, that were not reported to the Director (Refer WN #2).

During interviews, the DNC and the AGM both indicated that all of the above incidents were not reported to the Director. The AGM indicated that the licensee's expectation is when residents' exhibits sexual responsive behaviours the PCAs are to report the behaviours to the nurse in charge of the unit, who in turn report this to the RN, and the RN would contact the on call Manager.

The licensee failed to ensure that its Prevention of Abuse and Neglect policy #Tab 04-06 was complied with, specifically related to the registered nursing staff who had reasonable grounds to suspect sexual abuse involving resident #001, #002, #003, #004 and #008, did not report the information of which it is based to their supervisor. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone

Related to two Intake Log #'s 013620-17 and 014347-17 involving resident #001 and #002; and one Intake Log # 014929-17 involving resident #002 and #003:

There were 13 incidents of either suspected and/or witnessed incidents of sexual abuse involving resident #001, #002, #003 and #008 where investigations were not completed, (Refer WN #1 and #2).

During interviews, the DNC and the AGM both indicated that all of the above incidents were not investigated. [s. 23. (1) (a)]

2. Related to Intake Log #013871-17 involving resident #003 and #004:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time, for an incident of witnessed resident to resident sexual abuse involving

resident #003 and #004.

During an interview, the AGM indicated that both RPN #114 and RN #115 (who was in charge of the building) were aware of the above identified incident and did not notify the AGM who was on call that date, which resulted in the incident not being immediately investigated.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated, specifically related to resident #003 and #004 exhibited sexual responsive behaviours, and the incident was not investigated until four days later.

3. Related to Log #018914-17 involving resident #006 and #007:

There were 10 incidents of either suspected and/or witnessed incidents of physical/emotional abuse involving resident #007 that were directed towards resident #005, #006, #009 and #010 where investigations were not completed, (See WN #02).

During interviews, the DNC and the AGM both indicated that all of the above incidents were not investigated. [s. 23. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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. Related to Intake Log #013871-17 involving resident #003 and #004:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time for a witnessed resident to resident sexual abuse that occurred on identified date involving resident #003 and #004.

RPN #114 and RN #115 were not available for an interview during the inspection.

During an interview, the AGM indicated that both RPN #114 and RN #115 (who was in charge of the building) were aware of the above identified incident and did notify the AGM who was on call on the same date of the incident, nor was the Ministry of Health and Long term Care (MOHLTC) notified, resulted in the incident not being reported to the Director immediately.

The licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically related to not reporting a resident to resident sexual abuse involving resident #004 and #003 until four days later to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Intake Log #013871-17 involving resident #003 and #004:

A Critical Incident Report was submitted to the Director on an identified date and time for a witnessed resident to resident sexual abuse that occurred on an identified date and time involving resident #003 and #004.

During an interview, the AGM indicated that both RPN #114 and RN #115 (who was in charge of the building) were aware of the above identified incident and did not notify the AGM who was on call that date, which resulted in the incident not being reported to the SDM immediately.

The licensee failed to ensure that the residents SDMs were notified within 12 hours

upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, specifically related to resident #003 and #004's SDMs not being notified of within 12 hours of an alleged and or suspected incident of resident to resident sexual abuse that occurred four days prior to reporting the incident.

2. Related to two Intake Logs #013620-17 and 014347-17 involving resident #001 and #002; and one Intake Log # 014929-17 involving resident #002 and #003:

There were 13 incidents of either suspected and/or witnessed incidents of sexual abuse involving resident #001, #002, #003 and #008 where the SDMs were not notified, (Refer WN #1 and #2).

During interviews, the DNC and the AGM both indicated that all of the above incidents were not reported to the residents' SDMs.

The licensee failed to ensure that the resident's SDM were notified within 12 hours of the alleged abuse or neglect investigation, specifically related to an alleged resident to resident sexual abuse involving resident #001, #002, #003 and #008.

3. Related to Log #018914-17 involving resident #006 and #007:

There were 10 incidents of either suspected and/or witnessed incidents of physical/emotional abuse involving resident #007 that were directed towards resident #005, #006, #009 and #010 where the SDMs were not notified, (Refer to WN #2).

During interviews, the DNC and the AGM both indicated that all of the above incidents were not reported to the residents' SDMs. [s. 97. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

Related to two Intake Log #'s 013620-17 and 014347-17 involving resident #001 and #002; and one Intake Log #014929-17 involving resident #002 and #003:

There were 13 incidents of either suspected and/or witnessed incidents of sexual abuse involving resident #001, #002 #003 and #008 where the police were not notified, (Refer WN #1 and #2).

During interviews, the DNC and the Administrator both indicated that all of the above incidents were not reported to the police.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, specifically related to the above identified incidents (Refer to WN #1). [s. 98.]

2. Related to Intake Log #013871-17 involving resident #003 and #004:

A Critical Incident Report was submitted to the Director on an identified date and time an incident of witnessed resident to resident sexual abuse that occurred on an identified date involving resident #003 and #004.

During an interview, the AGM indicated that both RPN #114 and RN #115 (who was in charge of the building) were aware of the above identified incidents and did not notify the AGM who was on call that date, which resulted in the incident not being reported to the police immediately.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, specifically related to resident #004 and #003 exhibited sexual responsive behaviours were not reported to the police until four days later. [s. 98.]

Issued on this 29 day of November 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JULIET MANDERSON-GRAY (607) - (A1)

Inspection No. / No de l'inspection : 2017_687607_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 010230-17, 013620-17, 013871-17, 014347-17, 014929-17, 018914-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Nov 29, 2017;(A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that:

1. All members of the management team of the home, including Registered Nurses and Registered Practical Nurses are educated on:
The Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation (O. Reg.)
79/10, specifically related to the following sections:
LTCHA s.24 - Reporting certain matters to the Director
LTHCA s.23 - Licensee must investigate, respond and act
LTHCA s.20 - Policy to promote zero tolerance
O. Reg. 79/10 s. 2 - Definition of abuse
O. Reg. 79/10 s. 97 - Notification re incidents
O. Reg. 79/10 s. 98 - Police notification

2. A process is developed and put in place whereby the Director of Care and/or delegates are reviewing all documentation and communication from the front line staff at least daily to determine if any resident abuse has occurred in the home.

3. If any person has reasonable grounds to suspect that resident abuse of any kind have occurred, including any suspicions, allegations or witnessed incidents of physical, emotional, verbal, sexual abuse, the licensee will immediately investigate and ensure that appropriate actions are taken as per

legislative requirements.

4. Every resident currently exhibiting responsive behaviours including altercations which may lead to abusive situations is assessed, the incidents and assessments are documented, and the plan of care is reviewed and revised, including, but not limited to the plan of care of resident #002, #003, #007 and #008, until effectiveness strategies are identified and implemented.

5. The licensee`s "Prevention of Abuse and Neglect" policy # Tab 04-06 is complied with, including, but not limited to requirements related to reporting to the Director, the SDM notification and police notification.

The plan shall be submitted on or before November 17, 2017 to LTCH Inspector-Nursing Juliet Manderson-Gray via fax at 613-569-9670 or via email at OttawaSAO.MOH@ontario.ca. The plan shall identify who will be responsible for each items and expected completion dates.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act "physical abuse" means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident;
"emotional abuse" means, any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Related to Log #018914-17 involving resident #006 and #007:

A Critical Incident Report (CIR) was submitted to the on an identified date and time, for an incident of witnessed resident to resident physical abuse that occurred on an identified date and time involving resident #006 and #007 that resulted in resident #006 sustaining an injury.

A review of the clinical health record indicated that resident #006 and #007 has

diagnoses that includes cognitive impairments.

A review of the progress notes for resident #007 for a five month time period, indicated there were additional incidents of resident to resident physical abuse/aggression and/or emotional abuse by resident #007 that were directed towards other residents, that were not investigated, had no documented evidence to indicate the recipient resident of the alleged abuse was assessed for injury or distress, reported to the Substitute Decision Makers (SDM), reported to the Director, or the police in relation to responsive behaviours (Refer to WN # 2 for details).

During an interview, PCA #113 indicated that resident #007 exhibits several identified responsive behaviours that includes targeting resident #006. PCA #113 indicated that when resident #007 exhibits these behaviours, the staff would redirect other residents from the resident, as resident #007 was difficult to redirect, as well as the staff would perform increase observations of resident #007.

During an interview, RPN #101 indicated that resident #007 can appreciate the consequences of his/her actions, in the moment, and further indicated that when the resident exhibited physical and emotional behaviours directed towards other resident's staff would redirect the resident.

2. Under O.Reg.79/10, s. 2(1) for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means, (b) 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.

Related to two Intake Log #'s 013620-17 and 014347-17 involving resident #001 and #002; and one Intake Log # 014929-17 involving resident #002 and #003:

A review of the clinical health records for resident #001, #002, #003, #004 and #008 indicated the residents has diagnoses that includes cognitive impairments.

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time for a incident of a witnessed resident to resident sexual abuse involving resident #001 and #002.

A second Critical Incident Report was submitted to the Director on an identified date and time for an incident of a witnessed resident to resident sexual abuse involving

resident #001 and #002.

A third Critical Incident Report (CIR) was submitted to the Director on an identified date and time for a witnessed incident of a resident to resident sexual abuse involving resident #002 and #003.

In addition to the above Critical Incident Reports, a review of the progress notes for resident #002, indicated there were several incidents of suspected and or witnessed sexual responsive behaviours involving resident #001, #003, #004 and #008, that were not investigated, had no documented evidence to indicate the recipient resident of the alleged sexual abuse was assessed for capacity at the time of each incident to determine consent, or to indicate the incidents were reported to the Substitute Decision Maker (SDMs), the Director, or the police as follows:

There were several incidents of sexual responsive behaviours involving resident #008 and resident #002 over a two month period and one on another an identified date, involving resident #002 and an unidentified resident. The plan of care was not updated to include interventions related to the residents consenting to sexual responsive behaviours until two month after the initial incident. The Director was not notified of any of the incidents within the two months period the incidents occurred, or after. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent.

There were several incidents of resident to resident sexual responsive behaviours involving resident #003 and #002 on three identified dates. Of the incidents identified, only one was reported to the Director. During one of the incidents, there was no nursing staff present as per plan of care to provide increase monitoring for resident #003. In addition, there was one incident of sexual responsive behaviours involving resident #003 and #004 and one involving an unidentified resident. (Refer to WN #2 for details)

There were also two incidents of resident to resident's sexual responsive behaviours involving resident #001 and #002 . The plan of care for resident #001 was not updated to include interventions related to the residents consenting to sexual responsive behaviours until a month later. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent. (Refer to WN #2 for details)

A review of the written plan of care for resident #002 and #001, indicated there were several interventions that were put in place two weeks prior to the inspection, related sexual responsive behaviours.

A review of resident #003's written plan of care indicated there several identified interventions related to responsive behaviours that were put in place a six weeks prior to the inspection. Further review of resident #003's written plan failed to locate interventions related to consent to sexual responsive behaviours.

A review of the written care plan for resident #001 that was in place on or after the above identified incidents and currently in place, failed to identify interventions related to resident #001's sexual responsive behaviours and how staff were to manage these behaviours.

During an interview, PCA #109 indicated resident #002 exhibited sexual responsive behaviours and further indicated these behaviours were directed towards resident #003 and #008. The PCA indicated all three residents seek each other out in a sexual manner.

During interviews, RPN #111 and #108 both indicated that resident #001 and #002 are cognitively impaired and were not able to consent to sexual responsive behaviours. Registered Practical Nurse #108 indicated that resident #002 was not capable of consenting to sexual activities and further indicated that both resident #003 and #008 are cognitively well to consent to sexual activities.

During an interview, the AGM indicated that resident #002 is deemed incapable of consenting, and cannot consent to sexual activities. The AGM indicated that a capacity assessment was not completed on resident #001, #002, #003, #004 and #008 to determine if the residents were able to consent to sexual activities at the time of each incident. The AGM indicated that the licensee's expectation is when residents' exhibits sexual responsive behaviours, the PCAs are to report the behaviour to the Nurse in charge of the unit, who in turn report this to the RN, and the RN would contact the on call Manager.

During an interview, Physician #118, indicated that resident #002 is competent, but was unable to comment as to whether or not the resident is able to consent to sexual activity, as he/she did not complete an assessment on the resident to determine the resident's capability to consent to sexual activity.

During interviews, the DNC and the AGM both indicated that some of the above specified incidents were not reported to the SDM's, the Director or the Police, as the incidents were not reported by the front line staff to the DNC.

The licensee failed to ensure that when there was actual sexual abuse involving resident #001, #002, #003, #004, and #008 the recipient residents were protected. The licensee also failed to ensure that when there was actual physical/emotional abuse directed by resident #007 towards resident #005, #006, #009 and #010 the recipient residents were protected.

The severity of this non-compliance is potential harm and the scope is pattern. The homes compliance history indicated LTCHA, 2007, s.19 (1) was issued as a Compliance Order, during a Resident Quality Inspection on October 9, 2015, (inspection # 2015_291552_0024). In addition, a Compliance Order related s. 19 (1) was also issued during a Critical Incident Inspection on July 2, 2015 (Inspection # 2015_396103_0043). There was evidence of ongoing sexual responsive behaviours involving resident #001, #002, #003, #004 and #008 that would indicate that these residents were not being protected from ongoing sexual abuse as evidence that the licensee submitted three Critical Incident Reports to the Director.

1. A Compliance Order was warranted as the scope and severity has demonstrated that there were a total of 13 incidents of sexual responsive behaviours involving resident #001, #002 #003, #004 and #008. In addition:

2. There were actual sexual abuse involving resident #001, #002, #003, #004, and #008, there was also physical/emotional abuse directed by resident #007 towards resident #005, #006, #009 and #010 as identified under LTCHA, 2007, s.19(1).(Refer to WN #1 and #2).

3.The SDMs of Resident #001, #002, #003, #004 and #008 were not always notified of the suspected or witnessed sexual abuse or physical/emotional abuse by resident #007 that were directed towards resident #005, #006, #009 and #010, as identified under O. Reg. 79/10, s.97(1).(Refer to WN #7).

4. Only when the Director was notified of a Critical Incident Report (CIR) of a suspected or witnessed incidents of resident to resident sexual abuse, that the police were notified, all other incidents were not reported to the police, as identified under

O.Reg.79/10, s.98. (Refer to WN #8).

6. The licensee did not immediately investigate all incidents of resident to resident suspected or witnessed sexual abuse involving resident #001, #002, #003, #004 and #008 or physical/emotional abuse by resident #007 that were directed towards resident #005, #006, #009 and #010, as identified under LTCHA, 2007, s. 23 (1) (a) (Refer to WN #5).

7. The licensee failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents was complied with as there were 13 incidents of either suspected and/or witnessed incidents of sexual, abuse involving resident #001, #002 #003 and #008.

DR # 001-The above written notification is also being referred to the Director for further action by the Director. (607)

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

Dec 15, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that:

1. All members of the management team of the home, including Registered Nurses and Registered Practical Nurses are educated on:
The Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation (O. Reg.)
79/10, specifically related to the following sections:

O. Reg. 79/10 r. 53 – Responsive behaviours
O. Reg. 79/10 r. 54 - Altercations and other interactions between residents.

2. The Personal Expression Resource Team (PERTH) and the interdisciplinary team shall identify factors that could potentially trigger altercations and potentially harmful interactions specifically related to resident #005 and #007, and implement interventions to effectively manage these responsive behaviours.

3. A process is developed and implemented to ensure the plan of care for resident #002, #006, #007 and #008 are reviewed and revised to incorporate the interventions identified by the Personal Expression Resource Team (PERTH) and the interdisciplinary team, to manage these responsive behaviours.

4. A process is developed and implemented to ensure all staff providing care knows which of the residents are at risk for altercations and potentially harmful interactions, and understand how and when to implement the planned interventions to manage responsive behaviours. The process should

be reviewed with all nursing staff, to ensure they are aware of their roles and responsibilities related to managing residents demonstrating the risk of altercations and potentially harmful interactions between and among residents.

5. A monitoring tool is developed and implemented to ensure the planned, revised interventions and strategies are effective in managing the responsive behaviours of resident #005 and #007, with special attention to minimizing risks associated with potential harmful interactions between resident #005, #007 and other residents.

6. The licensee`s" Personal Expression Program using the layered Natured Framework and the P.I.E.C.E.S Approach" policy #Tab 04-84 is complied with, including ensuring clear direction is provided to all staff about the referral process to the PERTH Team and when to refer to the external Psychogeriatric Resources.

The plan shall be submitted on or before November 17, 2017 to LTCH Inspector-Nursing Juliet Manderson-Gray via fax at 613-569-9670 or via email at OttawaSAO.MOH@ontario.ca. The plan shall identify who will be responsible for each items and expected completion dates.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; and strategies are developed and implemented to respond to these behaviours, where possible and actions are taken to respond to the needs of the resident, including reassessments and interventions and that the resident's responses to interventions are documented.

Related to Intake Log #'s 014929-17 involving resident #002 and #003, Log #013871 -17 involving resident #003 and #004, and Log #013620-17 involving resident #001 and #002:

A review of the clinical health records for resident #001, 002, #003, #004 and #008 indicated that the residents had diagnoses that includes Cognitive Impairments.

A review of the progress notes for resident #001, #002, #003, #004, and #008 over a five month time period, indicated that there were ongoing incidents of demonstrated sexual responsive behaviours by the residents that were directed towards each other as follows:

Related to resident #002 and #008:

There were five incidents of sexual responsive behaviours involving resident #008 and resident #002 between a two month time period and another one on an identified date, involving resident #002 and an unidentified resident.

Related to resident #002, #003 and #004:

There were four incidents of resident to resident sexual responsive behaviours involving resident #003 and #002. Of the five incidents, only one was reported to the Director. During one of the incidents there was no nursing staff present to provide increase monitoring for resident #003. In addition, there was one incident of sexual responsive behaviours involving resident #003 and #004 on an identified date and one on another identified date, involving an unidentified resident.

Related to resident #001 and #002:

There were also four incidents of resident to resident's sexual responsive behaviours involving resident #001 and #002. The plan of care for resident #001 was not updated to include interventions related to the residents consenting to sexual responsive behaviours until two months later. The Director was notified of only two of the incidents. There was no documented evidence that either residents were assessed after each incident of sexual responsive behaviours to determine capacity to consent.

A review of the written care plan for resident #001 that was in place on and after the above identified incidents, failed to identify any interventions or triggers related to resident #001's sexual responsive behaviours and how staff were to manage these behaviours.

A review of the written care plan for resident #004 that was in place on or prior to the inspection, and currently in place, failed to identify interventions or triggers related to resident #004's sexual responsive behaviours and how staff were to manage these

behaviours.

A review of the written care plan for resident #002 and #008 indicated that both residents had several interventions in place related to sexual responsive behaviours. Further review of the written plan of care for resident #002 and #008 failed to locate documented interventions related to the resident triggers related to sexual responsive behaviours.

During interviews, RPNs #105, #116, PCAs #117 and #109, all indicated that resident #002 and #008 exhibited sexual responsive behaviours directed towards each other and indicated that when the residents exhibited these behaviours staff would intervene and redirect resident.

During an interview, RPN #105 indicated not being aware of what some of the wording meant in relation to interventions in both residents care plans (#002 and #008). There were no documented interventions in the written plan of care to direct staff as to whether the residents were allowed touch each other or whether staff should be redirecting both residents, even though the interventions indicated both residents were consenting to sexual expressions.

A review of the clinical health records for resident #002 and #008 failed to locate documented evidence that either residents were a part of the (Personal Expression Program Layered Natured Framework (PERTH) program, (a behavioural assessment tool).

During an interview, the Neighbourhood Coordinator #117 indicated, that each unit had binders with referral related to the PERTH program, and indicated that any registered staff can refer a resident to the PERTH program. The Neighbourhood Coordinator #117 indicated that referral was not received for resident #002 or #008 related to the resident's behaviours and further indicated that both residents were not a part of the PERTH program and not being looked at in relation to their behaviours and triggers.

During an interview, an external Geriatric Consultant indicated that he/she believes resident #003 is unable to consent to sexual activities and feels the resident is cognitively impaired. The Consultant also indicated not receiving a referral for resident #002 or #008 in relation to their ongoing sexual responsive behaviours.

During an interview, the DNC indicated that both resident #008 and #002 were consenting to sexual expressions, and further indicated that a capacity assessment was not completed on either residents to determine if they had the capacity to consent to sexual activities after each identified incident.The DNC indicated the care plan does not provide clear directions to staff and indicated that both resident #002 and #008 are consenting to a sexual relationship, but there is a question of capability. The DNC indicated that the sexual expressions resident #002 and #008 displayed towards each other were ethical in nature and indicated he/she would have to consult with a corporate consultant to see how best to address the concerns. The DNC also indicated that resident #002 was moved more than once to different units during the above identified incidents and the home was thinking of performing another move, as the resident was now exhibiting these sexual responsive behaviours towards resident #008.

The strategy of referring resident #002 and #008 to the PERTH program or external geriatric consult was not considered by the licensee. Resident #002's written plan of care failed to identify triggers, when the resident exhibited ongoing sexual responsive behaviours involving three other residents (#001, #003 and #008). The written care plan for resident #004 that was in place on and after the above identified incidents and currently in place, failed to identify interventions or triggers related to resident #004's sexual responsive behaviours and how staff were to manage these behaviours. The Plan of care for resident #001 and #004 was not updated to include triggers identified in relation to both resident's sexual responsive behaviour. The licensee also failed to ensure that when actions were taken to respond to the needs of resident #002 including reassessment and interventions, that the resident response to those interventions were documented, as resident #002 was moved more than once to different units during the above identified incidents of sexual responsive behaviours, and the home was thinking of performing another move to another unit. The licensee also failed to ensure that there was documented evidence of how resident #002 responded to these interventions and that other strategies were considered in the revision of the plan of care. The licensee also failed to ensure that actions were taken to respond to the needs of the resident #002 and #008, including reassessments and interventions and that the resident's responses to interventions were documented, specifically related to resident #002 and #008 had ongoing sexual responsive behaviours and were not reassessed related to these behaviours.

2. Related to Log #018914-17 involving resident #006 and #007:

A Critical Incident Report was submitted to the Director on an identified date and time, for an incident of resident to resident physical abuse involving resident #006 and #007 that resulted in injury to resident #006.

A review of the clinical health records indicated that resident #007 had multiple diagnoses that includes Dementia. .

A review of resident #007's written plan of care related to responsive behaviours indicated the resident had several identified interventions in place.

During interviews, PCA #113 and RPN #101 both indicated that resident #007 exhibited responsive behaviours that were both verbal and physical in nature and further indicated that the resident is territorial of his/her space and would target resident #006. PCA #113 indicated that when resident #007 exhibits these behaviours the staff would redirect other residents from the resident, as resident #007 is difficult to redirect, as well as the staff would perform increase observations of resident #007.

A review of the clinical health records for resident #007 indicated that a Behavioural Assessment Tool (Layered Natured Framework Discussion Notes) was completed 17 months prior to the inspection. This was completed before the escalation of responsive behaviours of verbal and physical aggression towards other residents. The layered framework identified several behaviours exhibited by the resident and one intervention related to medication changes. There was no documented evidence to indicate actions had been taken to prevent risk of injury or harm to other residents either in written care plan or in the Layered Natured Framework Discussion notes (a behavioural assessment tool) within the last 17 months or after the incidents identified nor were all triggers related to these behaviours identified.

During an telephone interview, the Director of Nursing Care indicated that resident #007 was a part of the Personal Expression Resource Team (PERTH) program, and had a Personal Expression Program Layered Natured Framework, (a behavioural assessment tool) currently in place.

During an interview, the Neighbourhood Coordinator #117 indicated, that each unit had binders with referral related to the PERTH program, and indicated that any registered staff can refer a resident to the PERTH program. The Neighbourhood Coordinator #117 indicated that a referral was received for resident #007, 17 months

prior, and indicated that care plans are updated after each incident of resident's responsive behaviours. The Neighbourhood Coordinator #117 indicated there were no triggers identified in resident #007 written care plan related to the residents responsive behaviours.

A review of the progress notes for resident #007 for a six month time period, indicated resident #007 had several identified responsive behaviours in relation to verbal, emotional and physical abuse/aggression related to the resident's responsive behaviours.

The progress notes indicated, there were several incidents of resident to resident physical altercations and potentially harmful interactions involving resident #007 directed towards resident #006, #009, #010, #011 and an unidentified resident, one resulted in injury involving resident #007 and #006. There was no documented evidence that an interdisciplinary assessment was completed to identifying factors that could potentially trigger such altercations and interventions were not identified and or implemented until after the last CIR was submitted to the Director where resident #006 sustained an injury.

There was no intervention in the written plan of care of resident #006 to indicate how staff were to protect the resident from resident #007, considering interviews with staff and record review indicated resident #007 targets resident #006.

The licensee also failed to ensure that actions were taken to respond to the needs of the resident #007 and other residents, including reassessments and interventions and that the resident's responses to interventions were documented, specifically related to resident #007 had ongoing harmful interactive responsive behaviours that were directed at several residents and the resident was not reassessed related to these behaviours.

The severity of this non-compliance is both actual and potential harm and the scope is pattern. The home does have a history of non-compliance related to responsive behaviours that was issued as Voluntary Plan of Correction on October 9, 2015, during a Resident Quality Inspection. A compliance Order was warranted due to the scope and severity of identified incidents.

1. There were several incidents of resident to resident physical altercations involving resident #007 and three identified residents (#006, #009 and #010). The licensee

failed to ensure that, for each incident of demonstrated responsive behaviours by resident #007, all behavioural triggers for the resident were identified, where possible, as resident #007 had several incidents of resident to resident physical altercations where triggers were not identified. The written plan of care for resident #007 did not identified some behaviours exhibited by resident #007. The written plan of care was not revised to indicate all these responsive behaviours or related triggers. The only additional strategy considered was increase monitoring of resident #007, a day after the inspection was initiated, despite the resident continuing to demonstrate verbal and physical aggression/harmful interactions towards other residents.

2. The strategy of including resident #007 in the PERTH program was considered 17 months prior, however, actions were not taken to respond to the needs of resident #007, including reassessments and interventions as the written plan of care did not include the resident's responses to interventions trialed, neither were these responses documented, as the Layered Natured Framework Discussion notes for resident #007 was developed and implemented since 17 months prior and was not revised since then.

3. The written care plan was not updated until two months prior to the inspection, even though resident #007 exhibited several harmful interactions involving other residents as indicated above. There was also actual harm to resident #006 as a result of resident #007 targeting the resident, that resulted in injury to resident #006.

4. The strategy of referring resident #002 and #008 to the licensee's PERTH program or an outside Geriatric Consult was not considered by the licensee. Resident #002's written plan of care failed to identify triggers, when the resident exhibited ongoing sexual responsive behaviours involving three other residents (#001, #003 and #008).

5. The Plan of care for resident #001, #003, #004 and #008 also failed to identify triggers related to identified sexual responsive behaviours. The licensee also failed to ensure that actions were taken to respond to the needs of the resident #002 and #008, including reassessments and interventions and that the resident's responses to interventions were documented, specifically related to resident #002 and #008 had ongoing sexual responsive behaviours and were not reassessed related to these behaviours.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

DR # 002-The above written notification is also being referred to the Director for further action by the Director. (607)

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

Dec 15, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 29 day of November 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JULIET MANDERSON-GRAY

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Service Area Office / Bureau régional de services : Ottawa