Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2013	2013_220111_0006	O-000209-13	Critical Incident System

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1

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

LYNDA BROWN (111), CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 14, 18, 19, 20, and telephone interviews on 25, 26, 28 and April 18, 2013.

Inspectors attended the home to conduct an inspection of 1 critical incident (log 000084) related to abuse, 1 complaint (log 000235)pertaining to abuse and 1 critical incident (log 000209)pertaining to two violent incidents at the home resulting in physical injury of one resident and the death of another resident.

During the course of the inspection, the inspector(s) spoke with Residents and Family, Executive Director (ED), members of the Board of Directors, Police, Director of Care (DOC), members of the Family Council, Physician, Nurse Managers, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Maintenance personnel.

During the course of the inspection, the inspector(s) reviewed resident health records, reviewed minutes from Board of Directors, reviewed the homes policies on Prevention of Abuse, Responsive Behaviours, and Emergency Plans (Code White), staff training, staff schedules, Registered staff and Personal Support staff meeting minutes, and 24 hour daily client reports.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Summary of Facts:

A review of clinical health record indicated Resident #1 was admitted to the Wexford in March 2011.

2.Upon admission, Resident #1 required extensive assistance managing his activities of daily living, including staff assistance with meals, continence and transfers. The resident used a wheelchair for mobility. Clinical documentation describes the resident as slightly confused, displaying an anxiousness that required the resident to be approached in a calm and gentle manner.

3. Between March 2011 to September 2011 Resident #1's physical and cognitive status had improved significantly since admission. Documentation indicated Resident #1 attended recreational/social programs, was able to leave the floor, wander throughout the home or outside if accompanied by staff, and continued to use his wheelchair for mobility.

4. On September 28, 2011 Resident #1 was transferred to the 6th floor as a result of the resident's improved health status.Documentation indicated that when Resident #1 was told he was being moved, the resident cried and stated he "did not want to move off the unit to the 6th floor".

5. Between September 28, 2011 to December 2011, Resident #1 demonstrated responsive behaviours of verbal aggression on at least 2 separate occasions:
•October 29, 2011 – Resident #1 was verbally aggressive toward staff
•November 25, 2011 – Resident #1 was verbally aggressive toward staff

6. On December 2011: RAI-MDS quarterly assessment for Resident #1 triggered the Mood State RAP. RAP summary indicated Resident #1 "at times gets angry with the other residents on the unit, when the resident believes that they are picking on his friends, has been heard shouting and yelling by staff on the unit. Staff will often have to intervene and provide [him]one-to-one to allow him an opportunity to verbalize his feelings. His mood is easily altered."

7. Between December 2011 and April 2012, Resident #1 demonstrated responsive behaviours of verbal aggression on at least 8 separate occasions and 3 of those incidents were physical abuse:

•January 15, 2012 – Resident #1 yelled, belittled, swore, and threatened Resident #5, as well as yelled and swore at Resident #4. When staff removed Resident #1 from the conflict and tried to calm him, he remained angry and threatened to physically harm Resident #5 and threatened to "fix" Resident #4
•January 19, 2012 – Resident #1 verbally aggressive towards staff
•January 21, 2012 – Resident #1 grabbed Resident #5's hand, and threw a pen at Resident #5's face
•February 10, 2012 – Resident #1 yelled at staff
•March 3, 2012 – Resident #1 belittled staff
•March 5, 2012 – Resident #1 smacked Resident #5 across the head; the police were notified and came to speak with both residents
•March 20, 2012 – Resident #1 grabbed Resident #5's arm, which caused a skin tear; the police were notified and came to speak with both residents
•March 31, 2012 – Resident #1 and Resident #4 had an altercation that resulted in Resident #4 falling and fracturing a hip. The police were notified and they came to the home. The police did not lay charges.

8. On March 29, 2012 RAI-MDS annual assessment: for Resident #1 triggered the Psychosocial Well-Being and the Mood State RAPS. RAPS summary indicated "has adjusted well to the unit. He is very sociable and friendly at times, situations where the resident gets frustrated, and anger with residents on unit is expressed verbally and physically. Continues to participate in various programs but requires reminders." The Mood State RAP indicated that Resident #1 "is persistently angry with staff and other residents on the unit. His behaviour is often present when he sees one of his friends in an argument with another resident. His mood is often easily altered."

9. On April 5, 2012, Resident #1 was transferred to the 2nd floor after the conflicts with Resident #4 and #5.

10. On April 10, 2012 the attending physician assessed Resident #1 and ordered a psycho-geriatric consult because of the ongoing conflicts and demonstrations of aggressive behaviour.

11. On April 13, 2012 a psycho-geriatric consult was completed. The psychiatrist recommended an anti-anxiety medication. The psychiatrist's report states Resident #1: "is irritable in mood, is not suicidal or homicidal".

"people annoyed the resident and therefore the resident took action by hitting out at them", Resident #1 "is probably a chronic risk to other residents in the home" and "may be a better candidate for placement elsewhere such as a psychiatric group home environment where there would not be frail elderly people who he might prey upon and the police may want to consider actually charging him if he commits further assaults".

12.On May 8, 2012 the attending physician assessed Resident #1 because he refused to take the medication prescribed by the psychiatrist. The physician discontinued the medication. No other assessment of Resident #1's verbal and physical aggressive responsive behaviours was conducted by the attending physician after that date.

13. Between April 2012 to June 2012 Resident #1 demonstrated responsive behaviours of verbal and physical aggression on at least 4 occasions and one of these incidents was verbal abuse:
•May 4, 2012 – Resident #1 confronted Resident #6's substitute decision maker
•May 19, 2012 – Resident #1 threatened Resident #6's substitute decision maker
•June 1, 2012 – Resident #1 was physically aggressive toward staff
•June 4, 2012 – Resident #1 called Resident #6 derogatory names

14. On June 2012 RAI-MDS quarterly assessment for Resident #1: triggered the Mood State RAP. RAP summary states that Resident #1 "has been heard shouting at another resident when arguments arise. Staff will often have to intervene and provide [him]one-to-one to allow him an opportunity to verbalize his feelings. His mood is easily altered."

15. Between June 2012 to September 2012 Resident #1 demonstrated responsive behaviours of verbal and physical aggression on at least 3 occasions:
•July 21, 2012 – Resident #1 belittled, swore and yelled at Resident #6.
•August 13, 2012 – Resident #1 and Resident #5 screamed at each other in the gift shop
•September 19, 2012 – Resident #1 physically intimidated Resident #6 (he approached Resident #6 as though he wanted to hurt the resident) and when staff intervened, Resident #1 was verbally aggressive toward the staff.

16. On September 2012 RAI-MDS quarterly assessment for Resident #1 triggered the

Psychosocial Well-Being, Mood State, Behavioural Symptoms RAPs. The Mood State and Behavioural Symptoms RAPs indicated that Resident #1 "is persistently angry with (Resident #6), who constantly screams and shouts especially at night and sleep is disturbed. Has been heard shouting and yelling at the resident. Staff often have to intervene and provide [him]one-to-one counselling to allow him with opportunity to verbalize his feelings. However, his mood is easily altered."

17. On September 26, 2012, Resident # 1 was transferred again but to the 3rd floor due to ongoing conflict with resident # 6. Documentation confirmed Resident #1 "was excited about this move" saying "I have been promoted just one step".

18. Between September 2012 and December 2012 Resident #1 demonstrated responsive behaviours of verbal and physical aggression on at least 2 occasions:
•November 24, 2012 – Resident #1 was verbally aggressive toward staff
•November 27, 2012 – Resident #1 swore at Resident #3 and approached Resident #3 in a "menacing manner".

19. On December 2012 RAI-MDS quarterly assessment for Resident #1: triggered the Mood State RAP. The RAP states that Resident #1 "often gets angry at other residents as well as (Resident #6), verbalizes cannot sleep because (Resident #6) keeps making noise at night. Is easily annoyed by other resident's in the lounge area.

20. On January 12, 2013 Resident #1 demonstrated responsive behaviours of verbal aggression when Resident #1 and Resident #3 screamed at each other, using abusive language

21. On February 19 ,2013 Resident #1 was transferred back to the 6th floor. The reason for this transfer and the resident's reaction to the transfer was not documented.Interview with the DOC indicated the transfer was related to requiring the ceiling lift in the room for a heavier care resident.

22.On February 25, 2013 Resident #1 demonstrated responsive behaviours of physical abuse when Resident #1 hit Resident #5 with the back of his hand and then attempted to hit Resident #5 with his cane, but was unsuccessful because of staff restraining.

23. On February 2013 RAI-MDS annual assessment for Resident #1: triggered the

Behavioural Symptoms RAP. The RAP states that Resident #1 displays physically abusive symptoms toward others.

24.Between February 2013 and March 2013 Resident #1 demonstrated responsive behaviours of verbal and physical aggression on at least 3 occasions and one of these incidents was verbal abuse:
•March 3, 2013 – Resident #1 spoke inappropriately to Resident #5 at breakfast in the dining room
•March 5, 2013 – Resident #1 threatened to harm Resident #5 if Resdient #5 bothered Resident #1 any further and belittled Resident #5.
•March 7, 2013 – Resident #1 made inappropriate comments to Resident #5.

25. On March 11, 2013 Resident #1 punched Resident #5 in the face. Resident #1 was transferred back to the 2nd floor and placed in a private room due to conflict with Resident #5. The Evening Staff(S#120) assigned to care for Resident#1 (on the 2nd floor at the time the Resident was transferred), did not know the resident, thought he stayed in his room most of the time, and was not aware of any behaviours or prior history of aggression. Clinical documentation related to this move indicates Resident #1 stated "it feels like I'm being segregated". Evening Staff as (#S104) stated Resident #1 said he was being "treated like a guinea pig, being moved everywhere". Resident #1 stated he "did not regret hitting Resident #5" and "he would do it again".

26. On March 12, 2013 Resident #1 displayed aggressive, demeaning and belittling behaviours toward a nursing staff member and waved his cane aggressively at the same staff member.

27. On March 13, 2013:
•at approximately 14:30 hours Resident #1 went outside. A student saw him leaving and asked him whether he was allowed to leave on his own.The student reported the encounter to the Day Staff(#S117) on the 2nd floor and the Day Staff(#S117) documented Resident #1 was annoyed at having been confronted, but he did not exhibit aggressive behaviours.
•The Day Staff(#S117) asked the Evening Staff(#S113) on the 2nd floor to monitor Resident #1 hourly between 15:00 hours and 23:00 hours using the Behaviour Tracking Tool. The Day Staff(#S117) requested the hourly monitoring because of Resident #1's aggressive behaviour the day before, because of his confrontation with the student, and because Resident #2 had expressed a fear of Resident #1 earlier in

the day.
•The Evening Staff(#S113) was told by Resident #2 that she was afraid of Resident #1 and when Resident #1 previously resided on the second floor, they had an altercation. The Evening Staff (#S113) used the Behaviour Tracking Tool(Appendix A to the Licensee's Management of Responsive Behaviours Policy) to monitor Resident #1. The Evening Staff(#S113) noted on the Tool that the resident was monitored hourly from 15:00 to 20:00 hours. The Tool indicated between 21:00 and 23:00 hours, Resident #1 was "sleeping". Interview of the Evening Staff(#S113) confirmed that Resident #1 was not checked between 21:00 and 23:00 hours.
•The Evening Staff(#S121) assigned to care for Resident #1 from 15:00 to 23:00 hours was not aware that Resident #1 was on hourly monitoring, was not advised of Resident #1's history of aggression or potential for responsive behaviours, and was not advised of the reason for his transfer to the 2nd floor.
•At 22:30 hours the Evening Staff(#S121) saw Resident #1 fully dressed and walking in the hall.
•At 23:00 hours there was a scheduled change of shift from evening staff to night staff. One of the Night Staff (#S108) is in charge of the building.This Night Staff(#S108) was on the 3rd floor at 23:00 hours.
•At approximately 23:00 hours Resident #1 walked past the nursing station on the 2nd floor. The Evening Staff(#S113) asked Resident#1 where he was going. Resident #1 said he "could not sleep and was going for a walk".
•At approximately 23:05 hours, the Evening Staff(#S113) and the Night Staff(#S106) working on the 2nd floor heard a scream and ran toward it. They saw Resident #1 exit Resident #2's room. Resident #1 threatened the staff with his cane and then walked away. The Evening Staff(#S113) ran back to the nursing station and called 911. The Night Staff(#S106) went into Resident #2's room and found Resident #2 with multiple injuries.
•At approximately 23:10 hours, immediately after calling 911, the Evening Staff (#S113) telephoned the Night Staff(#S108) who was on the 3rd floor to inform that Resident #1 had hit Resident #2.
•The Night Staff(#S108) hung up the phone and while running to the 2nd floor, saw Resident #1 entering the 3rd floor unit. The Night Staff(#S108) stopped Resident#1 and said "I heard you hit someone on the 2nd floor?". Resident #1 responded, "Yes." The Night Staff (#S108) left Resident #1 on the 3rd floor and proceeded to the 2nd floor. The Night Staff(#S108) did not control, impede, or attempt to control or impede Resident #1's movements. The Night Staff(#S108) did not speak to anyone else before reaching Resident #2's room.

•At the same time, the other Night Staff(#S125) on the 3rd floor was making rounds. The Night Staff(#S108)did not tell the other Night Staff (#S125) on the 3rd floor about the incident on the 2nd floor or that Resident #1 was now on the 3rd floor.
•Resident #1 then walked into Resident #3's room and inflicted multiple and ultimately fatal wounds to Resident #3.
•The Night Staff (#S125) on the 3rd floor heard faint screaming, called out, "Who's screaming?" There was no response. The Night Staff(#S125) saw Resident #1 leave Resident #3's room. The Night Staff(#S125) was "petrified and thought something terrible had happened" and did not go into the room.
•The Night Staff(#S125) ran down the stairs to the 2nd floor and told the Night staff (#S108) and the Evening Staff(#S113) what was observed. No one controlled, impeded, or attempted to control or impede Resident #1's movements.
•Resident #1 left the 3rd floor and proceeded to the 5th floor where another Night Staff (#S107) came out of the elevator and asked Resident #1 where he wanted to go. This Night Staff (#S107) was not aware of the incidents on the 2nd and 3rd floors. Resident #1 said he wanted to go to the 6th floor. The Night Staff(#S107) then accompanied Resident #1 into the elevator to the 6th floor.
•When the Night Staff(#S107) and Resident #1 entered the 6th floor unit, the Night Staff(#S126) responsible for residents on the 6th floor (and who knew Resident #1) asked Resident#1 why he was on the 6th floor. Resident #1 attempted to enter Resident #5's room, but the 6th Floor Night Staff(#S126) blocked the door. Resident #1 attempted to hit the staff member with his cane. The 6th Floor Night Staff(#S126) tried to grab the cane and Resident #1 fell. The other Night Staff(#S107) ran to the nursing station to call for assistance and spoke with a Maintenance staff who then came to assist. The staff on the 6th floor were not aware of the incidents that had occurred on the 2nd or 3rd floors. Together the staff moved Resident #1 into a chair and his actions were now controlled.
•While Resident #1 was on his way up to the 6th floor, the Night Staff(#S108) ran from the 2nd floor back up to the 3rd floor and went into Resident #3's room. Resident #3 was bleeding heavily from multiple wounds, eyes were swollen shut, and was not responsive. The Night Staff(#S108) believed Resident #3 was dead.
•The Night Staff(#S108) ran to the nursing station and called 911. Then went back to Resident #3's room to wait for the paramedics and the police and stayed there until the paramedics arrived.
•The paramedics arrived at approximately 23:35 hours. They could not resuscitate Resident #3. The paramedics transferred Resident #2 to the hospital.
•Police arrested Resident #1 and removed him from the home.

The Licensee failed to protect residents from abuse by Resident #1 as shown by the summary of facts and the following:
1.The Licensee failed to protect residents, in particular Resident #2 and Resident #3 from physical abuse. The applicable definition of physical abuse in O.Reg. 79/10 of the LTCHA is "the use of physical force by a resident that causes physical injury to another resident."
2.The licensee failed to protect residents from emotional abuse. The applicable definition of emotional abuse in O.Reg. 79/10 under the LTCHA is "any threatening or intimidating gestures, actions, behaviours 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."
3. The licensee failed to protect residents from verbal abuse. The applicable definition of verbal abuse in O.Reg. 79/10 under the LTCHA is any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.
4.Between January 2012 and March 2013, and prior to the incidents on March 13, 2012, Resident #1 demonstrated the following responsive behaviours of verbal, emotional and physical abuse towards other residents as follows:

a.On January 15, 2012 Resident #1 was arguing with Resident #5. Both residents were swearing at one another. Resident #1 was also shouting obscenities at Resident #4 because Resident #4 had turned off the T.V. while he was watching it. He made threatening motions towards Resident #4 while swearing at Resident #4. Staff removed Resident #1 from the area and spoke to him for 5 minutes to calm him. He remained angry and threatened to "mess up" Resident #5 and "fix" Resident #4 the next day.

b.On January 21, 2012 Resident #5 was tapping a pen on a table in the common area and Resident #1 became verbally aggressive towards Resident #5, then grabbed the pen and threw it in Resident #5's face. Staff intervened and removed Resident #1 and spoke to him to calm him down.

c.On March 5, 2012 Resident #1 smacked Resident #5 across the head. The DOC witnessed the smack and removed Resident #1 from the area and reminded him that it was not appropriate behaviour. Resident #1 said Resident #5 provoked him. Police were notified.

d.On March 20, 2012 Resident #1 and Resident #5 were in the lounge and Resident

#1 asked Resident #5 to stop banging the table with the pen. Resident#5 refused and he grabbed Resident#5 arm and tore the skin. Resident #1 left the area on his own. Staff later spoke to him and reminded him that he was not to touch other residents. Resident #1 again claimed he was provoked. Police were notified.

e.On March 31, 2012 Resident #1 and Resident #4 had an altercation that resulted in Resident #4 falling and sustaining a broken hip. Police were notified.

f.Between May 2012 and September 2012 there were 4 incidents where Resident #1 demonstrated responsive behaviours of verbal aggression towards Resident #6 and Resident #6's substitute decision maker as indicated in the summary of facts.

g.On November 27, 2012 Resident #1 swore at Resident #3 and approached Resident #3 in a menacing manner. Staff told Resident #3 to ignore him.

h.On January 12, 2013 Resident #1 and Resident #3 screamed at each other using abusive language. Staff had to separate the residents and try to calm them down.

i.On February 25, 2013 Resident #1 hit Resident #5 with the back of his hand and then attempted to hit Resident#5 with his cane, but staff intervened, took away the cane and separated the residents.

j.On March 3, 5 and 7, 2013 Resident #1 demonstrated responsive behaviours of verbal aggression, as well as physical intimidation, toward Resident #5.

k.On March 11, 2013 Resident #1 punched Resident #5 in the face. He said that he "did not regret hitting Resident#5" and said "he would do it again".

5.Resident #1 also demonstrated responsive behaviours of verbal and physical aggression toward staff on many occasions between October 2011 and March 2013. While not directed toward residents, the behaviours were indicative of Resident #1's pattern of violence.

6.The Licensee failed to protect residents from abuse through a pattern of inaction and/or inappropriate and insufficient action that is shown by the following:

a.Some staff members knew that Resident #1 would react with anger, both verbally and physically, if he perceived a situation or incident as unacceptable to him. His specific response was often unpredictable.

b.Resident #1 began demonstrating responsive behaviours of verbal aggression toward staff in October of 2011. By January of 2012 Resident#1 responsive behaviours had escalated to physical aggression and were directed toward other residents.

c.The strategies implemented to manage Resident #1's behaviours were insufficient and ineffective:

i.When Resident #1 demonstrated responsive behaviours of aggression, staff

would remove the resident from the scene after an incident took place and try to calm him down, telling Resident #1, he was not supposed to touch other residents. This did not deter him from doing it again.These interventions were not effective in managing Resident #1's responsive behaviour.

ii.Interventions to manage Resident #1's behaviours were not put into his plan of care until March 5, 2012 after he struck Resident #5 and police were notified. These interventions were not effective in managing Resident #1's responsive behaviour and the interventions were not reviewed and updated, nor were alternatives considered.

iii.Resident #1 was moved 5 times over the course of 18 months. Three of those 5 times were because of his aggressive behaviours. Resident #1 expressed anger and frustration at being moved after at least 3 of those moves. Staff failed to monitor the effectiveness of this strategy (moving the resident)and the impact on the resident's behaviours and did not consider alternatives to moving the resident when the verbal and physical aggression towards other residents continued.

iv.In April of 2012 the attending physician ordered a Psycho-geriatric consult for Resident #1. The psychiatrist recommended an anti-anxiety medication, which the attending physician ordered for Resident #1, but Resident #1 refused to take it. Staff did not inform the physician of Resident #1's ongoing responsive behaviours of aggression after May 8th, 2012. No other actions or strategies were implemented based on the psychiatrist's report as indicated in the summary of facts. Resident #1's plan of care was not reviewed or revised with strategies to manage his responsive behaviours after May 8th, 2012.

v.Staff did not use the Behaviour Tracking Tool until 18 months after Resident #1 began demonstrating responsive behaviours of verbal and physical aggression. The tool was not used until March 13, 2013 and was for hourly monitoring between the period of 15:00 to 23:00 hours. The Evening Staff(#S113) did not actually monitor the resident between 21:00 and 23:00 hours. At 23:00 hours that night, Resident #1 attacked and caused serious physical injuries to Resident #2, and attacked and caused serious physical injuries to Resident #3 causing her death.

d.The Licensee's policy, "Management of Responsive Behaviours," which provided other strategies for managing responsive behaviours was not followed. In particular, the involvement of the PIECES Resource Nurse for assessment and development of strategies to minimize his inappropriate behaviours. Refer to the written notification of non-compliance under s. 53(4)of the O.Reg.79/10.

e.Resident #1's plan of care did not identify behavioural triggers. Resident#1 was not reassessed and the plan of care was not reviewed and revised when Resident #1 began demonstrating responsive behaviours, and when his responsive behaviours of

verbal and physical aggression continued such that it was apparent the interventions were not effective.

f. When the RAI-MDS quarterly assessments for Resident #1 RAPs were triggered related to his aggressive behaviours, the plan of care was not updated to consider alternative approaches to manage his behaviours. The effectiveness of the interventions and strategies employed to manage his behaviours (with the exception of the medication that Resident #1 refused to take) were not evaluated. Refer to the written notification of non-compliance under s. 6(10) of the LTCHA.

g. Certain staff members were aware of ongoing conflicts between Resident #1 and Resident #5. Resident #1 demonstrated responsive behaviours of verbal and physical abuse and/or aggression toward Resident #5. The police were called on 2 separate occasions after Resident #1 struck Resident #5. Each resident was a behavioural trigger for the other, but neither resident's plan of care identified this. No strategies were developed to manage the conflict. On February 19, 2013 Resident #1 was moved back to the 6th floor where Resident #5 resided, which almost immediately led to an escalation of their conflict and lasted approximately 3 weeks until Resident #1 was moved back to the 2nd floor on March 11, 2013 when Resident #1 hit resident #5 earlier that day. Resident #1 indicated he did not regret hitting Resident #5 and felt that he was being segregated as indicated in the summary of facts.Staff did not consider alternatives to moving Resident #1 for the 5th time in 18 months. Staff did not consider the impact of these moves on Resident #1.

h.Staff failed to monitor and provide strategies to protect Resident #3, #4, #5 and #6. There were multiple altercations between Resident #1 and these four residents, but these conflicts were not communicated to staff who provided care to the resident and no strategies were put in place to protect these residents from Resident #1's responsive behaviours. Strategies to avoid conflict were not developed and implemented.

i.There was no effective communication between and among staff, either orally or through the plan of care, about how to manage Resident #1's behaviours. There were specific staff members who were more adept at managing Resident#1's behaviours, but neither the names of these staff members or the strategies they used were communicated to other staff. The plan of care did not provide clear direction to staff on how to implement interventions to manage Resident #1's behaviours, on evaluation of interventions, and on management of conflict. Refer to the written notification of non-compliance with s. 6 of the LTCHA.

j.Information about Resident #1's history of behaviours and the risk he posed to other residents was not conveyed to staff members responsible for caring for the resident

on multiple occasions. For example, on March 11, 2013 when Resident #1 was moved back to the 2nd floor, information about his behaviours, the incident on the 6th floor that took place earlier that day where Resident#1 hit Resident #5 was not communicated to staff on the 2nd floor, in particular the staff who was assigned to care for the residents on the 2nd floor, including Resident #1. In an interview with the Evening Staff(#S120) assigned to care for the residents on the 2nd floor at the time Resident #1 was transferred to the 2nd floor said that the resident was not known, thought Resident#1 stayed in the room most of the time, and was not aware of any behaviours or prior history of aggression. Further, on March 13, 2013, the Evening staff(#S121) assigned to care for the residents on the 2nd floor, including Resident #1, was not aware that Resident #1 had to be monitored, was not advised of Resident #1's history of aggression or potential for responsive behaviours, and was not advised of the reason for Resident#1's transfer to the 2nd floor.

k.The Licensee's Zero Tolerance of Abuse and Neglect of Residents policy does not "contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents" as required by s. 96(b) where the person who abused or neglected or allegedly abused or neglected is a resident. Neither does the policy identify "measures and strategies to prevent abuse and neglect." Refer to the written notification of non-compliance with s. 96 of O.Reg. 79/10.

10.In addition to the above, the Licensee failed to protect residents from abuse by Resident #1 on March 13, 2013 as follows:

a.Resident #1 was moved to the 2nd floor on March 11, 2013 following an altercation between Resident #1 and Resident #5 on the 6th floor. Resident #1 said he was not sorry and would do it again and he was very upset at being moved. Resident #1's history of aggressive behaviours was not communicated to all staff providing care to Resident #1. No steps were taken to monitor Resident #1 or any procedures and interventions put in place to protect other residents who were at risk of harm as a result of Resident #1's behaviours.

b.Earlier in the day on March 13, 2013, Resident #2 told the Day Staff(#S117) that Resident#2 was afraid of Resident #1. The Day Staff(#S117) asked the Evening Staff (#S113) to monitor Resident #1 hourly between 15:00 hours and 23:00 hours using the Behaviour Tracking Tool. The Day Staff(#S117) said in an interview that the Evening Staff(#S113) was asked to monitor Resident #1 because he had demonstrated responsive behaviours of aggression the day before, because of his confrontation with the student earlier that day, because Resident #2 expressed fear, and because Resident #1 had just moved to the 2nd floor on March 11, 2013. The

Day Staff(#S117) had not cared for Resident #1 before and was not aware of his history of aggressive behaviours. No other steps were taken to protect Resident #2.

c.Around the early evening on March 13, 2013, Resident #2 told the Evening Staff (#S113) that Resident#2 was afraid of Resident #1 and that when he previously resided on the 2nd floor they had an altercation. The Evening Staff(#S113) did not tell anyone else and did not take any steps to protect Resident #2 other than to monitor Resident #1 hourly using the Behaviour Tracking Tool. However, the last notation on the chart says "sleeping" between 21:00 hours and 23:00 hours, but in an interview, the Evening Staff(#S113) said Resident #1 was not actually seen between 21:00 hours and 23:00 hours.

d.The Evening Staff(#S113) did not call a Code White. At approximately 23:05 the Evening Staff(#S113) and the Night staff(#S106) working on the 2nd floor heard a scream and ran toward it. They saw Resident #1 coming out of Resident #2's room. Resident #1 threatened them with his cane and then walked away. No one tried to stop Resident #1. The Evening Staff(#S113) called the police and called the Night Staff(#S108) on the 3rd floor regarding Resident #1 hitting Resident #2.

e.The Licensee has a policy called "Code White" for violent/aggressive situations. Nobody called a Code White that night. According to the policy, "Restraints may be initiated by a staff member in a situation when there is imminent risk of harm to resident safety".

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The Licensee failed to comply with s. 96 in that it failed to ensure the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;

2. As indicated in the Summary of Facts, on March 13, 2013, Resident #1 attacked and caused serious physical injuries to Resident #2, and then attacked and caused serious physical injuries to Resident #3 causing death and staff did not take any steps to contain, control or impede Resident#1's movements until the resident reached the 6th floor and attempted to enter Resident #5's room.

3.In "Section Three: Actions to Be Taken by Staff Role and Responsibilities" of the Policy, employees or Board Members who are reporting that they have witnessed or suspect an alleged incident of resident abuse or neglect are to "intervene if safe to do so, or identify needed interventions (e.g. call 911) to ensure resident/staff safety and well-being." This does not amount to "procedures and interventions" to actually deal with the person who abused or neglected or allegedly abused or neglected.

4. Where "a staff member" abused or neglected, or allegedly abused or neglected, a resident, the Policy only provides instruction for managing that staff member. It does not contain procedures or interventions to deal with "a resident' who abuses another resident.

5. The Policy also does not identify "measures and strategies to prevent abuse and neglect." [s. 96. (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to log 000235:

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

A Critical Incident (CI) was received on March 6, 2012 a resident to resident abuse incident that occurred in the home. The CI indicated that resident #1 was sitting in the TV lounge watching TV and then got up and walked towards resident #5 and punched resident #5 in the face. Resident #5 was asked if they wanted to call the police, the resident #5 stated "no". The licensee did not call the police. [s. 98.]

2. Related to log 000084:

A CI was received on April 3rd, 2012 an incident of resident to resident abuse that occurred in the home. The CI indicated while in the lounge, resident #4 reported that resident #1 had pushed Resident #4 to the ground when Resident#4's back was turned. Resident #4 was transferred to hospital and sustained a fractured hip. Resident #1 indicated that when Resident #1 let go of resident #4's hand, Resident #4 lost balance and fell".Police were not called until April 2, 2012. [s. 98.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 comply with s. 6(1)(c) in that it failed to ensure the plan of care provided clear direction to staff.

The plan was revised on March 5, 2012 when Resident #1 struck Resident #5,to include the following interventions for the problematic behaviours. Staff did not reassess Resident #1, but did revised his plan of care to identify that Resident #1 had problematic behaviours characterized by anxiety, mistrust, conflict, anger, and verbal and physical aggression. It was also revised to include interventions to deal with his mood, i.e. negative feelings towards self and social relationships (low self esteem, anxiety, mistrust, conflict/anger):
i. Staff to discuss with the resident appropriate channelling of anger
ii. Document summary of each episode (note cause and successful interventions)
iii. Help resident to identify activities that will decrease angry behaviour
iv. Offer reading material
v. Remove resident from lounge when behaviour is disruptive/unacceptable
vi. Use calm and low pitch voice
vii. Staff to make other residents aware of resident's personal space
viii. Invite resident to attend socials and entertainment (dinner clubs and pub) off the unit that he enjoys
ix. Provide programs that he enjoys (reminiscing about where he grew up)
This finding of non-compliance is supported by the Summary of Facts and the following:
-Resident #1 exhibited a pattern of aggressive behaviours, including an escalation of those behaviours between October 2011 and March 2013.
-The written plan of care for Resident #1 did not identify the behaviour triggers for Resident #1, including his ongoing conflict with Resident #5. It did not identify that he was demonstrating responsive behaviours of verbal and/or physical aggression toward staff and residents. The plan of care did not provide clear directions to staff and others who provided him with direct care because the plan of care did not set out:
a.Resident #1's history of responsive behaviours of verbal and physical aggression;
b.how to monitor and manage his responsive behaviours, especially the verbally and physically aggressive behaviours, including how to evaluate strategies and interventions;
c.how to carry out the limited strategies and interventions as identified above to manage behaviours identified, including who to contact for assistance as there were certain staff members who were better able to manage the behaviours;
d.how to deal with, or help him avoid conflict with other residents, including

identifying altercations with Resident #3, Resident #4, Resident #5 and Resident #6.and,

e.that on March 13, 2013 the Evening Staff (#S113) was monitoring Resident #1 using the Behaviour Tracking Tool. [s. 6. (1) (c)]

2. The licensee failed to comply with s. 6(10)(b) in that it failed to ensure the plan of care was reassessed and revised when care needs changed and when the care set out in the plan was not effective for resident #1 related to mobility.

The written plan of care for mobility indicated the resident "has decreased mobility" and interventions included staff supervising the resident when ambulating. The plan of care was not reviewed and revised when his mobility needs changed, and when he no longer required staff supervision and when Resident #1 began independently using a cane and wheelchair for mobility. The plan of care does not contain any information about mobility devices. [s. 6. (10) (b)]

3. The licensee failed to comply with s. 6(10)(c) in that it failed to reassess the resident when the care set out in the plan related to responsive behaviours, was not effective as resident #1 continued to demonstrate verbal and physical aggression and/or abuse towards other residents.

This finding of non-compliance is supported by the facts set out in the Summary of Facts and the following:

1.In s. 2 of the LTCHA, "care" is defined to include treatment and interventions.

2.Resident #1 exhibited a pattern of aggressive behaviours, including an escalation of those behaviours, between October 2011 and March 2013.

3.The Licensee failed to reassess the resident, and failed to review and revise the plan of care for the resident at various points in time during that period. In particular:

a.Resident #1 demonstrated responsive behaviours that were verbally and/or physically aggressive and/or abuse on at least 29 documented occasions during the 18 month period, but he was not reassessed at any of these occasions, with the exception of two occasions where staff had already started the quarterly RAI-MDS assessment. The only assessments of Resident #1 during this 18 month period were the annual and quarterly RAI-MDS assessments. Staff failed to reassess Resident #1 and review and revise his plan of care:

i.when Resident#1's care needs changed, i.e. when the resident began demonstrating responsive behaviours and when those responsive behaviours

continued to escalate even after interventions were identified; and
ii.when the care set out in his plan of care was not effective, i.e. when the interventions in his plan of care to address aggressive behaviours were not effective.

b.Prior to Resident #1's move to the 6th floor in September 2011, he had not exhibited responsive behaviours. Following his move to the 6th floor, there were 2 documented occasions on which Resident #1 was verbally aggressive towards staff (October 29, 2011 and November 25, 2011). The verbal aggression was indicative of a change in his care needs and interventions were required to manage his responsive behaviours. Resident #1 was not reassessed and his plan of care was not reviewed and revised in respect of these responsive behaviours, even though his care needs had changed.

c.On December 2011 the quarterly RAI-MDS assessment for Resident #1 triggered the Mood State RAP. The RAP summary that Resident #1 "at times gets angry with the other residents on the unit, when he believes that they are picking on his friends. He has been heard shouting and yelling by staff on the unit. Staff will often have to intervene and provide [him]one-to-one to allow him the opportunity to verbalize his feelings. His mood is easily altered." The RAP summary states, "No referral required. During episodes of verbally aggression staff will take him to a quiet area and speak with him. Staff allow [him] to verbalize his feelings and then provide reassurance. These interventions have been effective at this time." Resident #1's plan of care was not reviewed or revised.

d.Following the December 2011 quarterly assessment, Resident #1's records reveal an escalation in his responsive behaviours. His aggressive behaviours were directed toward residents, as well as staff, and became physical, as well as verbal.

e.There are two documented incidents on January 15 and 21, 2012, respectively, where Resident #1's aggressive behaviours were directed toward other residents and escalated to both verbal and physical aggression. Resident #1 was not reassessed and his plan of care was not reviewed and revised. No interventions were identified for Resident #1.

f.On March 5, 20 and 31, 2012 there are three separate documented incidents where Resident #1 demonstrated verbal and physical aggression toward other residents. The police were called on each occasion. The police did not lay charges. Resident #1 was not reassessed following the incidents on March 5th and 20th.

g.On March 29, 2012 staff conducted the RAI-MDS annual assessment for Resident #1. During this assessment (specifically on March 31, 2012), Resident #1 had an altercation with Resident #4 who fell and broke a hip and the police were

called. Despite the physically aggressive behaviours exhibited in January and March, only two RAPs were triggered during this assessment, namely Psychosocial and Mood State. The Behavioural Symptoms RAP was not triggered. The Psychosocial Well-Being RAPs summary says that he "is very sociable and friendly at times. There has been situations where he does get frustrated and his angered with residents on unit and is expressed verbally and physically." The RAP was to be "care planned with the goal to continue encouraging the resident's involvement in the programs, interacting with residents appropriately". The RAP for Mood showed that he is persistently angry with himself or others up to 5 days per week and "he is often angry with the residents on the unit and staff, when his needs are not met right away." His mood is easily altered and the RAP summary goes on to say that this will be "care planned with the goal of improving his mood." Despite this, Resident #1's plan of care was not revised.

h.On April 10, 2012 the attending physician ordered a psycho-geriatric consult for Resident #1 because of his ongoing conflicts and demonstrations of aggressive behaviour. The psychiatrist met with Resident #1 and prepared a report on or around April 13, 2012. The psychiatrist recommended an anti-anxiety medication. Refer to the Summary of Facts for a summary of the psychiatrist's findings, including that Resident #1 was a chronic risk to other residents.

i.Staff failed to review and revise Resident #1's plan of care based on the findings of the psychogeriatric assessment, other than to obtain a physician's order for the medication recommended by the psychiatrist.

j.Resident #1 refused to take the medication recommended by the psychiatrist and was referred back to the attending physician who discontinued the order for the medication. The physician said in an interview that the physician was not aware of Resident #1's responsive behaviours of verbal and physical aggression after April 2012. The medication was not an effective treatment for his aggressive behaviours, but the Resident was not reassessed and his plan of care was not reviewed or revised in respect of these behaviours.

k.On April 5, 2012 staff moved Resident #1 to the 2nd floor because of his conflicts with Resident #4 and Resident #5. While on the 2nd floor, Resident #1 continued to demonstrate responsive behaviours, primarily verbally aggressive behaviours, toward other residents and staff. In particular, he was in conflict with Resident #6, whom he said made a lot of noise at night and he could not sleep. His ongoing responsive behaviours where evidence that the interventions were not effective, yet Resident #1 was not reassessed, and his plan of care was not reviewed or revised.

l.On June 18, 2012 the RAI-MDS quarterly assessment triggered the Mood RAP.

The RAP summary states that Resident #1 "has been heard shouting and yelling at another resident when argument arises. Staff will often have to intervene and provide [him] with one-to-one to allow him the opportunity to verbalize his feelings. His mood is easily altered." The RAP states that "referral will be made to complimentary one on one care." There is no evidence this referral was ever made.

m.Between June 2012 and September 2012 there were four incidents where Resident #1 demonstrated responsive behaviours of verbal aggression toward Resident #6, and one incident involving Resident #5. Resident #1 was not reassessed until the next RAI-MDS quarterly assessment that began in September 2012. The Psychosocial Well-Being, Mood State, and Behavioural Symptoms RAPs were triggered. This was the first time the Behavioural Symptoms RAP was triggered. The Mood State and Behavioural Symptoms RAPs state that Resident #1 "is persistently angry with one resident, Resident #6, who constantly screams and shouts especially at night and his sleep is disturbed. He has been heard shouting and yelling at Resident #6. Staff have often have to intervene and provide [him] with one-to-one counselling to allow him opportunity to verbalize his feelings. However, his mood is easily altered." The summary also indicated that "DOC and other disciplines will be involved in developing a strategic plan to reduce the stressor, and creating a friendly atmosphere for all residents...This RAP will be care planned with the focus of improving his mood and avoiding complications to other residents or himself." The summary shows a referral "To DOC for relocation of rooms" and to "Activation to schedule activities to keep [his] time occupied." Despite this, Resident #1's plan of care was not revised. On September 26, 2012 staff moved Resident #1 to the 3rd floor.

n.On 2 separate occasions, November 24 and 27, 2012, Resident #1 demonstrated responsive behaviours of verbal and physical aggression toward staff and another resident, respectively. Resident #1 was not reassessed and his plan of care was not reviewed and revised even when he continued to exhibit these behaviours and the care was, therefore, not effective. The strategy of moving Resident #1 was not evaluated for its effectiveness.

o.On December 18, 2012, the RAI-MDS quarterly assessment for Resident #1 triggered the Mood State RAP. The RAP states that Resident #1 "often gets angry at other residents as well Resident #6, he verbalizes that he cannot sleep because Resident #6 keeps making noise at night. He is easily annoyed by other staff in the lounge area. The RAPs summary goes on to say that his "anger is not easily altered, staff try to diffuse the situation by taking the other residents away from him." This RAP "will be care planned with the goal to reduce mood Indicators." Despite this, his

plan of care was not revised.

p. Resident #1's responsive behaviours of verbal aggression continued with another incident in January 2013, yet he was not reassessed and the care and interventions in his plan of care pertaining to responsive behaviours was not reviewed or revised.

q. On February 2013 the RAI-MDS annual assessment for Resident #1 triggered the Behavioural Symptoms RAP. The summary states that Resident #1 "displays physically abusive symptoms towards others"-refer to Summary of Facts. The treatment and interventions in his plan of care were not revised pertaining to these behaviours.

r.Even though Resident #1 and Resident #5 had ongoing conflict with one another and Resident #1 exhibited responsive behaviours of verbal and physical aggression toward Resident #5, on February 19, 2013 staff moved Resident #1 back to the 6th floor where Resident #5 resided. Following this move, there are 4 documented incidents where Resident #1 demonstrated responsive behaviours of verbal and physical aggression toward Resident #5. Resident #1 was not reassessed and his plan of care was not reviewed or revised pertaining to these behaviours. Resident #1 was moved back to the 2nd floor on March 11, 2013. Resident #1 was upset at having to move again and said he "felt like was being segregated" and "he was being treated like a guinea pig because he was being moved everywhere". Moving Resident #1 was an ongoing strategy implemented to deal with Resident #1's behaviours, but this intervention was not identified in the plan of care and it was not effective since he continued to exhibit these behaviours after every move. Staff moved him a total of 5 times over an 18 month period. Staff identified that 3 of these moves were a result of Resident #1's aggressive behaviours. Resident #1 expressed his anger and frustration at being moved. The licensee failed to reassess and review and revise the plan of care when the intervention of moving him was not effective to manage the aggressive behaviours. The licensee failed to ensure that different approaches were considered to manage his behaviours.

s.Despite the interventions set out in the plan of care on March 5, 2012, Resident #1's responsive behaviours of verbal and physical aggression continued, which shows that the interventions were not working. The resident was not reassessed and his plan of care was not reviewed and revised, with one minor exception. On October 3, 2012, a new intervention was added to the plan of care "try not to reason with resident when he resident is angry".

4.The written plan of care for Resident #1 did not identify the behaviour triggers for Resident #1, including his ongoing conflict with Resident #5. It did not identify the he demonstrated responsive behaviours of verbal and/or physical aggression toward staff

and residents. The plan of care did not provide clear directions to staff and others who provided him with direct care because the plan of care did not set out:
a.Resident #1's history of responsive behaviours of verbal and physical aggression;
b.how to monitor and manage his responsive behaviours, especially the verbally and physically aggressive behaviours, including how to evaluate strategies and interventions;
c.how to carry out the limited strategies and interventions to manage his behaviours identified, including who to contact for assistance as there were certain staff members who were better able to successfully manage his behaviours;
d.how to deal with, or help him resident avoid conflict with other residents, including identifying altercations with Resident #3, Resident #4, Resident #5 and Resident #6 in the written plan of care; and
e.that on March 13, 2013 the Evening Staff (#S113) was monitoring Resident #1 using the Behaviour Tracking Tool.
6.Resident #1's plan of care for mobility indicated that he resident had decreased mobility and staff had to supervise him when ambulating. Resident #1's physical condition improved, especially within the first six months he was in the home. The plan of care was not reviewed and revised when his mobility needs changed, he no longer required staff supervision and he began independently using his cane and wheelchair for mobility. The plan of care does not contain any information about mobility devices. As his condition improved, staff stopped supervising him. When he used his cane during responsive behaviours of physical aggression (e.g. February 24, 2013), his resident's mobility needs were not reassessed and his plan of care was not reviewed and revised to reflect the use of his cane in a threatening manner towards others during periods of anger. [s. 6. (10) (c)]

WN #5: 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 :

1. The licensee failed to comply with s.53(4)(a) in that the plan of care for Resident #1 failed to identify the behavioural triggers including: internal transfers and responsive behaviours resulting in aggression directed towards Resident #5, and other residents.

This finding of non-compliance is supported by the facts set out in the Summary of Facts and the following.

a.There was a pattern of conflict with certain residents, but the only resident identified as a trigger for Resident #1 was Resident #6, on the 2nd floor. Resident #5 and Resident #1 had on-going conflict with each other and Resident #1 demonstrated many responsive behaviours of verbal and physical aggression toward Resident #5, yet Resident #5 was not identified as a behavioural trigger for Resident #1.

b.Resident #1 demonstrated responsive behaviours of verbal aggression toward staff on at least 9 documented occasions over an 18 month period and RAI-MDS assessments on March 29, 2012, December 18, 2012, and February 18, 2013 which indicate behaviours toward staff, yet no specific behavioural triggers were identified.

c.Staff moved Resident #1 5 times over 18 months and 3 of these moves were related to his behaviours. Resident #1 reacted negatively to some of the transfers and expressed anger and frustration and being moved so frequently.

d.During interview, staff said that Resident #1 would react with anger, both verbally and physically, if he perceived a situation or incident as unacceptable. [s. 53. (4) (a)]

2. Related to log 000235:

The plan of care for Resident #5 failed to identify all behavioural triggers that contributed to responsive behaviours including interactions with resident #1 which resulted in on-going verbal and/or physical aggression between the two residents.

Review of the progress notes for resident #5 indicated that from January 2012 to March 2013 there were 6 verbal and/or physical aggressive incidents between resident #5 and resident #1. [s. 53. (4) (a)]

3. The licensee failed to comply with s.53(4)(b) in that the plan of care for Resident #1 failed to identify the strategies to manage resident #1's responsive behaviours.

a.The Licensee has a policy called "Management of Responsive Behaviours." This policy includes the following interventions, most of which were not implemented:

i.The policy says, "Notify and consult with physician when all the nursing interventions fail to manage the resident's behaviour." There was a psycho-geriatric consult, but the only intervention implemented was a new anti-anxiety medication, which was stopped within a month. Staff did not notify or consult the attending physician after May 8, 2012 when the attending physician stopped the medication recommended by the psychiatrist to manage Resident #1's behaviours.
b.The policy says, "Forward referral to PIECES Resource Nurse for assessment and development of strategies to minimize inappropriate behaviour." Resident #1 was never referred to the PIECES Resource Nurse.
c. The policy says, "Implement strategies and monitor resident closely to determine whether expected outcome is achieved." As set out in the written notification for non-compliance with s. 6 of the LTCHA, the licensee failed to reassess Resident #1 and review and revise his plan of care when the interventions were not effective and he continued to demonstrate responsive behaviours of verbal and physical aggression. Staff failed to monitor the Resident's response to the multiple moves, another strategy used to manage his behaviours, and his behaviours continued.
d.The policy says, "Document effectiveness of strategies on Behaviour Tracking Tool (Appendix A)." Staff only used the Behaviour Tracking Tool once, on March 13, 2013, 18 months after the responsive behaviours of aggression toward others began.
e.The policy says, "If the behaviour persists, forward referral to Psycho-geriatrician (who attends at The Wexford monthly) for assessment and treatment." This only happened once in April of 2012.
f.The policy says, "Consider referral to Psycho-Geriatric Resource person/POP Team (Psycho-geriatric Outreach Program) to assist with development of strategies to deal with behaviour and provide training and support to staff as they implement the strategies when delivering care." There was no indication that the POP team was referred to, to assist with the development of strategies.
g.The policy says, "Document strategies on care plan and review and update quarterly and more frequently as necessary." As set out in the written notification for non-compliance with s. 6, staff failed to review and update the strategies put in the plan of care on March 5, 2012, with one minor exception on October 3, 2012.
h.The policy says, "PIECES Resource Nurse along with the Interdisciplinary Care Team will review Behaviour Tracking Tool to ascertain effectiveness of strategies as necessary." Staff did not use the Behaviour Tracking Tool until March 13, 2013, 18 months after Resident #1 began demonstrating responsive behaviours of aggression, and on that same day Resident #1 attacked and caused serious physical injuries to Resident #2, and attacked and caused serious physical injuries to Resident #3

causing her death.
i.The policy says, "Staff shall document effectiveness of strategies used in managing resident behaviour in his/her chart." Staff did not document in Resident #1's chart the effectiveness of the limited strategies used. [s. 53. (4) (b)]

4. The licensee failed to comply with s.53(4)(c) in that they failed to ensure that strategies were developed and implemented to respond to resident #1 responsive behaviours, and actions were taken to meet the needs of the resident including reassessments:
a.Staff referred Resident #1 for a psycho-geriatric consult, but the only intervention implemented from that consult was to administer an anti-anxiety medication that Resident #1 refused to take. No other intervention was implemented.
b. As set out in the written notification for the finding of non-compliance with s. 6 of the LTCHA, staff failed to reassess Resident #1 when he continued to demonstrate responsive behaviours of verbal and physical aggression. The limited interventions identified in his plan of care on March 5, 2012 were not reviewed and revised and different approaches were not considered as his behaviours continued.
c.One intervention was to move Resident #1. He was moved 5 times over 18 months, but he continued to demonstrate responsive behaviours or verbal and physical aggression toward residents and staff after each move. He had ongoing conflict with Resident #5, yet staff moved him back to the same floor as Resident #5 on February 13, 2013. [s. 53. (4) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to comply with s.55(a) in that it failed to ensure procedures and interventions for responsive behaviours were implemented to assist residents and staff who are at risk of harm or to minimize the risk of altercations and potential harmful interactions between and among residents.

This finding of non-compliance is supported by the facts set out in the Summary of Facts and the following:
-Over a period of 18 months, between September, 2011 and March, 2013, Resident #1 demonstrated responsive behaviours of verbal and physical aggression toward staff and residents.
-The Licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of Resident #1's behaviours, and to minimize the risk of altercations and potentially harmful interactions between residents.
-Resident #1 and Resident #5 had on-going conflict towards one another and were involved in at least 9 separate altercations. Resident #1 demonstrated responsive behaviours of physical aggression toward Resident #5 on at least 4 separate occasions. On two occasions the police were called. The only procedures and interventions developed and implemented to manage this conflict and to protect Resident #5 from harm from Resident #1's aggressive behaviour was to separate the residents after an altercation had occurred and, after multiple altercations, to move Resident #1 to another floor. Despite their conflict having been ongoing for close to a year, staff moved Resident #1 back to the same floor as Resident #5 on February 13, 2013.
-When Resident #1 lived on the 2nd floor, he was persistently angry with Resident #6. There were 4 documented altercations between Resident #1
and Resident #6 where Resident #1 demonstrated responsive behaviours of verbal aggression toward Resident #6 and this continued for a period of 5 months and the intervention used was to relocate Resident#1 to another floor.
-On November 27, 2012 and January 12, 2013 Resident #1 demonstrated responsive behaviours of verbal and physical aggression toward Resident #3. The only procedure and intervention developed and implemented to manage this conflict and to protect Resident #3 from harm from Resident #1's aggressive behaviour was to separate the residents during each altercation.
-The strategy of moving Resident #1 to a different floor did not minimize the risk of altercations since the altercations and his responsive behaviours of aggression toward others continued after every move. Furthermore, moving Resident #1 contributed to

his anger and frustration. Resident #1 was upset after 3 out of the 5 moves and expressed anger and frustration at being moved.
-The Licensee failed to ensure that Resident #1's behavioural triggers were identified, strategies were implemented to respond to his behaviours and sufficient actions were taken to respond to his needs, contrary to s. 53(4) of the Regulation. Resident #1's responsive behaviours of verbal and physical aggression put residents and staff at risk of harm. Many of the interventions and strategies identified in the Licensee's Management of Responsive Behaviours policy were not implemented. See the written notification of non-compliance with s. 53(4) of the Regulation for further detail.
-On March 13, 2013 Resident #2 told the Evening Staff (#S113) that Resident#2 was afraid of Resident #1 who had just been moved back to the 2nd floor two days earlier. Resident #2 told the staff member that when Resident #1 had last resided on the 2nd floor they had an altercation. The staff member did not tell anyone about this and the only strategy implemented to minimize the risk of altercations or potentially harmful interactions between these residents was the implementation of the Behaviour Tracking Tool, which was utilized to monitor Resident #1 on an hourly basis between 15:00 hours and 23:00 hours that evening. [s. 55. (a)]

2. The licensee failed to ensure all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to others, including residents and staff as follows:
-On March 11, 2013, Resident #1 punched Resident #5 in the face. This was the 4th altercation of physical aggression Resident #1 demonstrated toward Resident #5 while residing on the 6th floor. In an interview with staff member (#S120) assigned to care for the residents on the 2nd floor (on March 11, 2013 when Resident #1 was moved to the 2nd floor), said that the staff member did not really know the resident, and was not aware of any behaviours or prior history of aggression.
-On March 11, 2013, neither the 24 hour Nursing Report, nor any other document available to the direct care staff identified Resident #1 as a resident whose behaviours required heightened monitoring because those behaviours pose a potential risk to others.
-On March 13, 2013 the Day Staff (#S117) asked the Evening Staff (#S113) to monitor Resident #1 hourly between 15:00 hours and 23:00 hours using the Behaviour Tracking Tool. In an interview with the Evening Staff (#S113) assigned to care for the residents on the 2nd floor (including Resident #1), said that the staff member was not aware of any monitoring of Resident #1 and was not informed of the reason he moved

to the 2nd floor and was not advised of Resident #1's history of responsive behaviours of aggression or his potential for such behaviours. The 24 hour Nursing Report did not identify Resident #1 as a resident whose behaviours required heightened monitoring because those behaviours pose a potential risk to others. [s. 55. (b)]

Issued on this 27th day of May, 2013

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

Lynda Brown (#111), [signature] (#166)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), CAROLINE TOMPKINS (166)
Inspection No. / No de l'inspection :	2013_220111_0006
Log No. / Registre no:	O-000209-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 22, 2013
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

To achieve compliance with the duty to protect residents from abuse by residents who demonstrate responsive behaviours of verbal and/or physical aggression and/or abuse, the Licensee shall:

1. Identify all residents in the home who have demonstrated or demonstrate responsive behaviours of verbal and/or physical aggression and/or abuse towards others. Conduct a risk analysis to identify all other residents who are vulnerable to abuse by a resident demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse and take steps to protect those residents from abuse based on the outcome of this analysis;
2. Assess and/or reassess every resident identified as having demonstrated or demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse toward others using the RAI-MDS assessment tool and any other assessment tool(s) specific to responsive behaviours, review and, if necessary, revise the plan of care based on the assessment(s);
3. Develop and implement specific strategies to respond to the behaviours of every resident in the home who has demonstrated or who demonstrates responsive behaviours of verbal and/or physical aggression and/or abuse toward others. Create and implement a system for communicating these strategies to all their direct care staff;
4. Review and revise the plan of care for every resident identified as having demonstrated or demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse toward others to ensure that the plan of care:
(i) provides clear direction to staff and others who provide direct care to the resident in the management of those responsive behaviours, including how to monitor and manage the responsive behaviours, and the direction must reflect the actual care provided related to responsive behaviours,

ii) identifies behavioural triggers for the resident, where possible, including other residents with whom the resident has had one or more altercations,
(iii) identifies and documents strategies and interventions to respond to and manage the resident's responsive behaviours, and
(iv) identifies specific staff member(s) able to manage the resident's behaviours and who can be a resource to other staff members;
5. Where a resident demonstrates responsive behaviours of verbal and/or physical aggression and/or abuse toward another resident and the interventions are not effective because the behaviours are continuing, reassess the resident and review and revise the plan of care for the resident based on that assessment and ensure that different approaches are considered;
6. Develop an ongoing process for monitoring and evaluating the effectiveness of strategies and interventions for a resident demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse toward others;
7. Develop an ongoing process for identifying when the interventions for a resident demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse toward other residents, are not effective. Train staff on this process and on the requirements of s. 6(10)(c) of the LTCHA to reassess the resident and review and revise the resident's plan of care when the care, including treatment and interventions, set out in the plan has not been effective;
8. When one or more RAPs is triggered on a RAI-MDS assessment related to responsive behaviours of verbal and/or physical aggression and/or abuse, review and revise the plan of care set out based on the assessments;
9. Update and revise the "Management of Responsive Behaviours" policy immediately to identify strategies to deal with a resident demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse toward another resident. Train staff on what is required to comply with the updated policy of "Management of Responsive Behaviours";
10. Identify residents who are at risk of harm or actually harmed as a result of a resident's responsive behaviours of verbal and/or physical aggression and/or abuse. Develop and implement procedures and interventions to assist residents who are at risk of harm or who are harmed as a result of a resident's responsive behaviours, and to minimize the risks of altercations and potentially harmful interactions between and among residents. Develop and implement a method of communicating to all staff, the names of the residents at risk of harm or actually harmed and the procedures and interventions in place to prevent harm;
11. Train staff on how to identify a resident whose responsive behaviours require heightened monitoring because those responsive behaviours pose a

potential risk to one or more residents, and ensure that all direct care staff are advised at the beginning of every shift of the identified resident(s);
12. With respect to the emergency plans for violent outbursts in the home, immediately:
(a)Investigate and analyze why the emergency plan dealing with violent outbursts, i.e. Code White was not implemented on March 13, 2013 when Resident #1 attacked and caused serious physical injuries to Resident #2 and then attacked and caused serious physical injuries to Resident #3 causing her death;
(b) Review and update the plan for violent outbursts in the home based on this analysis and to include a requirement to follow up after the incident is managed to identify any learning or improvements required to the plan; and
(c) Retrain all staff on the revised emergency plan for violent outbursts.

The licensee shall comply with Orders 9 & 12 immediately.

The licensee shall prepare, submit and implement a plan for complying with Orders 1-8, 10 and 11 and identify who will be responsible for completing all of the tasks identified in these Orders and when the Orders will be complied with.

This plan is to be submitted to Lynda Brown by May 31, 2013 via email at Lynda.Brown2@ontario.ca. The date for complying with Orders 1-8, 10 and 11 shall not be later than June 30, 2013.

Grounds / Motifs :

1. As is set out in the inspection report:
a. The Licensee failed to protect residents from abuse by anyone pursuant to s. 19 of the LTCHA;
b. The Licensee failed to comply with s. 6(1) and (10) of the LTCHA;
c. The Licensee failed to comply with s. 53(4) of O.Reg. 79/10;
d. The Licensee failed to comply with s. 55 of O.Reg. 79/10; and
e. The Licensee failed to comply with s. 96 of O.Reg. 79/10.

2. The licensee failed to ensure the emergency plan and communication related to management of violent outbursts "code white" was effective as it failed to:
-clearly identify when to activate the plan
-which registered staff would have the authority to activate the plan
-how the plan was to be communicated
-did not provide specific roles and responsibilities to guide staff when working on a night shift.
-did not identify who is responsible for what when the plan is activated and,
-Resident #1 was able to proceed to three floors without restraint despite injuring one resident and injuring another fatally as code white was not fully implemented.

3. The severity of the harm and risk of harm to residents arising from the non-compliance was very high. On March 13, 2013 Resident #1 attacked and caused serious physical injuries to Resident #2, attacked and caused serious physical injuries to Resident #3 causing her death, and then attempted to enter Resident #5's room before he was apprehended as identified in the inspection report.

4.The scope of the harm and risk of harm arising from the non-compliance is widespread. All residents are at risk of harm where the Licensee fails to protect them from abuse by other residents demonstrating responsive behaviours of verbal and/or physical aggression and/or abuse. In the specific circumstances involving Resident #1, at least 5 residents were at risk of harm or actually harmed by Resident #1 as identified in the inspection report. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall amend its policy to promote zero tolerance of abuse and neglect of residents, called "Zero Tolerance of Abuse and Neglect of Residents"
i. to include procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; and
ii. to identify measures and strategies to prevent abuse and neglect.

Grounds / Motifs :

1. The Licensee failed to comply with s. 96 in that it failed to ensure the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;

2. As indicated in the Summary of Facts, on March 13, 2013, Resident #1 attacked and caused serious physical injuries to Resident #2, and then attacked and caused serious physical injuries to Resident #3 causing her death and staff did not take any steps to contain, control or impede his movements until he reached the 6th floor and attempted to enter Resident #5's room.

3.In "Section Three: Actions to Be Taken by Staff Role and Responsibilities" of the Policy, employees or Board Members who are reporting that they have witnessed or suspect an alleged incident of resident abuse or neglect are to "intervene if safe to do so, or identify needed interventions (e.g. call 911) to ensure resident/staff safety and well-being."

4. The above policy does not amount to "procedures and interventions" to actually deal with the person who abused or neglected or allegedly abused or neglected.Where "a staff member" abused or neglected, or allegedly abused or neglected, a resident, the Policy only provides instruction for managing that staff member. It does not contain procedures or interventions to deal with "a resident' who abuses another resident. The Policy also does not identify "measures and strategies to prevent abuse and neglect."

(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 22nd day of May, 2013

Signature of Inspector / Signature de l'inspecteur : LBrown (#111), (#166)

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN / CAROLINE TOMPKINS

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