Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2017;	2017_397607_0001 (A1)	002087-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment to this report was made to CO #01, timeline to daily monitoring process was changed from 3 months to 2 months, no change was required to the compliance Order date.

Issued on this 24 day of March 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 24, 25, 26, 30, 31 February 1, 2, 13, 14 and 15, 2017

During this Complaint Inspection, the following intakes were inspected: Log's # 001904-17 and 002087-17.

Summary of Intakes:

1) Log #s 002087-17 and 001904-17: Regarding an alleged staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Nursing Student, Personal Support Workers (PSWs), a Student Personal Support Worker, a Substitute Decision Maker (SDM) and a Resident.

During the course of the inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to Zero Tolerance of Abuse, Dementia Care Assessment and Careplanning, Responsive Behaviours and Skin and Wound.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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

- **6 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from Physical Abuse by Personal Support Worker #114.

Under O.Reg.79/10, s. 2(1), for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Logs #002087-17 and #001904-17:

A Critical Incident Report was submitted to the Director in January, 2017, at an identified time, for an incident related to an alleged staff to resident physical abuse that occurred on an identified date and time. The CIR indicated that resident #001 was being care for by Personal Support Worker #114, when the resident became resistive to care, sustaining injuries to the resident body parts. A complaint was also submitted to the Ministry of Health and Long-Term Care in January 2017, at an identified time in regards to the above identified incident, indicating the Substitute Decision Maker (SDM) had not been informed of how the incident occurred, or that an investigation was being conducted by the home.

Record review of resident's #001 clinical health records by Inspector #570 and #607, indicated that resident #001 was admitted to the home on an identified date, with multiple diagnosis that includes Dementia.

Review of progress notes for resident #001 for the period of August, 2016, to February 2017, indicated the resident had exhibited multiple responsive behaviours.

In an interview with resident #001’s SDM in January and February, 2017, by Inspector #607, it was indicated that in January 2017, Registered Nurse (RN) #106 had contacted the SDM and informed the SDM that resident #001, had sustained an injury to a body part and will be transferred to the hospital for further assessments and treatments. The SDM indicated that RN #106 was asked how the resident sustained the injuries and there were no answers from the RN. The SDM further indicated that he/she had gone to see resident #001 at the hospital, after speaking with RN #106. Upon arrival at the hospital, the SDM indicated that he/she had observed resident #001 dressed in a long sleeve turtle neck top and did not notice any injuries to the resident. However, he/she had observed bandages on the resident’s body parts. The SDM indicated, that the attending Physician informed him/her at that time, that there were injuries to resident #001’s body part. The SDM further indicated, that the resident informed him/her that he/she did not know how the injuries were acquired, but indicated that a staff

member had hurt him/her. The resident was discharged from hospital and returned to the home later. The SDM indicated, upon arrival to the home, he/she had asked staff how the resident had sustained the injuries, and no one at the home was able to give him/her an answer, nor was he/she notified at this point that an investigation was being conducted into the incident. The SDM further indicated, that he/she had asked a family member to go by the home to see resident #001 in January 2017 on another identified date, and further indicated that after the family member arrived at the home, the family member had contacted him/her and ask him/her to come and see resident #001, as multiple injuries were noted to the resident's body. The SDM indicated, upon arrival at the home, he/she observed resident #001 to have multiple injuries to his/her body parts. At which time, he/she took pictures, went to see the police and later informed the Ministry of Health and Long-Term Care. The SDM indicated, he/she had visited the home once again, on another identified date in January, 2017, and during his/her visit, the Director of Care approached him/her, they had a meeting, and it was at that time, the DOC had informed him/her that an investigation had been initiated, regarding the above identified incident and further informed him/her that PSW #114 was relieved from duty, pending investigations, this was 72 hours later, after the incident.

A review of a Head to Toe assessment record for resident #001, dated January 2017, at an identified time indicated that the resident was assessed after returning from hospital and multiple skin impairments were identified. Further review of resident #001's clinical health care records failed to locate documented evidence indicating the Substitute Decision Maker (SDM) of the resident was notified of the identified skin impairments.

In an interview with resident #001 in February 2017, by Inspectors #607 and #507 the resident indicated that a staff member had hurt him/her. The resident was unable to identify who the staff member was, but indicated that the staff member was seen before working on the unit, prior to the incident.

In an interview with RN #106 in February 2017, by Inspectors #607 and #507, indicated that on the date of the incident, the housekeeping staff #114 had informed him/her that resident #001 had an injury and needed help. RN#106 and RN student #105 went to the resident's room. Upon arrival, the resident was observed by RN #106 seated in a room with an injury to the resident's body part, while Personal Support Worker (PSW) #114 was observed standing next to the resident. The RN indicated, that he/she observed multiple injuries to the resident The RN further indicated, that at this point, he/she had asked PSW #114 how the

resident sustained the injuries, and the PSW indicated that the resident was resistive to care. The RN also indicated, that while speaking with PSW #114, the PSW was continuing to provide care to resident #001; when the resident asked the PSW not to touch him/her and pointed to the injury to his/her body part. The RN further indicated that it was at that point, he/she indicated to PSW #114 to stop providing care to the resident and indicated no further question was asked to the PSW. RN #106 indicated, he/she had asked RN student #105 to go and get the Director of Care (DOC), while he/she applied ice and a temporary dressing to resident #001's body part. During this time, the DOC arrived, assessed the resident, and had contacted the Physician from another floor to assess the resident. The resident was assessed by the Physician, who further indicated, that the resident required further treatment and ordered that resident #001 be sent out to the hospital for further assessments and treatments. RN #106 further indicated, that he/she contacted resident #001's SDM and had notified the SDM that the resident had sustained an injury and would be transferred to the hospital. The resident's attending physician was also notified, and the paramedics were contacted. The resident was later transferred to hospital for further assessments.

In an interview with RN student #105, by Inspectors #607 and #570 in February, 2017, the student confirmed the incident occurred the same as RN #106 described, but indicated witnessing resident #001 to be upset and had heard the resident telling PSW #114 "to stay away from him/her". The RN student further indicated that he/she was instructed by RN #106 to go get the DOC, which he/she did, and both the DOC and the Clinical Manager came to see resident #001.

In an interview with PSW #104, who was working at the time the incident occurred, by Inspectors #607 and #570 in February, 2017, the PSW indicated that resident #001 requires limited assistance with care. PSW #104 indicated that at no time during the shift did PSW #114 had indicated to him/her that resident #001 had refused or was resistive to care. PSW #104 further indicated, that he/she had gone in to see the resident when he/she learned of the incident, and had observed resident #001 seated in a room, while RN #106 was applying ice to the resident's body part. PSW #104 indicated the resident was visibly upset, and was shouting at PSW #114 to get away from him/her.

In an interview with RN #112 and PSW #102 by Inspectors #607 and #570 in February, 2017, both indicated that resident #001 was assessed upon returning from hospital on January, 2017, and confirmed the above identified injuries.

In an email received by Inspector #607, in February, 2017, at an identified time from a Detective from Durham Regional Police, the Detective indicated that PSW #114 was arrested and charged with assault causing bodily harm.

1. The licensee's policy #CARE3-P10 in relation to responsive behaviours was not complied with, specific to implementing the STOP tool in managing the responsive behaviour for resident #001, resulting in the resident sustaining multiple injuries to the resident's body parts. The licensee also failed to ensure that it's Skin and Wound policy #CARE12-010.05 was complied with, specifically related to entering a treatment on the Treatment Administration Record (TAR/eTAR) for resident #001, specifically related to skin impairments to the residents body part, as identified under O. Reg. 79/10, s. 8. (1) (b), (Refer to WN #02).

2. The licensee failed to ensure the resident SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, specifically related to resident #001, as identified under O. Reg. 79/10, s.97 (1) (Refer to WN #05).

3. The Licensee failed to ensure that when resident #001 demonstrated ongoing verbal and physical aggression and other responsive behaviours, the behaviours triggers were not identified where possible, and strategies to manage the responsive behaviour were not developed and implemented where possible; nor were actions taken to respond to the resident needs including reassessment and interventions to the responses were documented, as identified under O. Reg. 79/10, s. 53 (4) (Refer to WN #04).

4. The licensee failed to ensure that the plan of care for resident #001 was based on interdisciplinary assessment with respect to sleep patterns and preferences, specific to not including interventions related to when the resident awakens, until after an incident in January, 2017, and the resident's bedtime, as identified under O. Reg.79/10, s. 26. (3) 21 (Refer to WN #03).

The licensee does not have a history of non-compliance with LTCHA, 2007 S.O. 2007, c 8, s.19, however, there was actual harm of physical abuse by PSW #114 directed towards resident #001, as evidenced by the licensee submitting a report to the Director, as identified under LTCHA, 2007, s. 24, conducted an investigation, as identified under LTCHA 2007, s. 23, taken action in response to the incident by

relieving PSW #114 from duty pending investigations, later terminated the PSW and the PSW was subsequently charged with assault causing bodily harm on February 9, 2017, as identified under O. Reg. 104 (1). Based on the severity and the negative outcome experienced by resident #001 a Compliance Order was warranted. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 901

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

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

A review of the home's investigation notes and interviews with staff, indicated that PSW #104, RN student #105, Housekeeping staff #103 and RPN #108 were either present, responded to or discovered the above identified incident, but were not identified in the CIR.

The licensee has failed to ensure that the report to the Director included the names of all staff who responded, were present or either discovered the incident, specifically related to resident #001. [s. 104. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident and the names of staff members who responded or are responding to the incident., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's Skin and Wound policy #CARE12-010.05 is complied with specifically related to Skin and Wound care for resident #001.

O. Reg. 79/10, s.30. (1) requires the licensee to ensure that there is an organized program in place and complied with under section 48 of the regulation:
1. There must be a written description of the program that includes its goals, and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
O. Reg. 79/10 s.48 (1) requires the home to have a Skin and Wound Program.

A review of the Licensee's Skin and Wound Care policy #CARE12-010.05 directs:
Policy:
LTC - Skin and Wound Care Program
Steps:
Management of skin tears
1) Unregulated Care Providers (UCP) will report any skin tears to the Nurse
2) Assessment and documentation: Complete Skin Tear Assessment (STAR); Assessment completed a minimum of every seven days until closed, included dressing intact and there are no signs of infection; determine the root cause; document in progress notes when skin tear is closed.
4) Treatment: Refer to Skin Tears Algorithm in the Revera/3M clinical Resource Guide for skin and Wound Care; further prevention interventions implemented
5) Risk Management: completed incident report/RMM as appropriate; Record all Skin Tears on the Monthly Skin Integrity Report

6) Notify and document on initial, worsening and closure: Notify SDM; Report skin tears to the Wound Care Champion (WCC), Physician; Enter treatment on the Treatment Administration Record (TAR/eTAR)
7) Referrals: Registered Dietitian(RD) - Nutritional Care Referral Form; Wound Care Champion (WCC); Physician/NP as required
8) Plan of Care: Initiate/update Resident's plan of care to reflect the skin tear as altered skin integrity focus, including current goals and interventions; Resolve plan of care when skin tear is closed.

Review of clinical health records for resident #001 indicated the resident was assessed by the Physician, who was present at the home at the time of incident in January, 2017. The Physician's note indicated the resident was agitated during care when the resident sustained injuries to the resident's body parts.

A review of the Treatment Administration Records (TAR) for resident #001 dated January 2017, had interventions of how to care for one of the injury sustained, however, there was no documented evidence indicating how often or what treatment was to be completed for another injury sustained to the residents body part.

Interview with RN #106 by Inspector #607 and #570,on an identified date in February, 2017, indicated that the home uses Revera/3M protocol for skin tears and the protocol is to apply Tegaderm dressing to residents sustaining skin tears and this would be in place for 21 days. The RN further indicated the treatment for resident #001's body part was not and should have been listed on resident's TAR for January, 2017.

Interview with the DOC in February, 2017, by Inspector #607 and #570, indicated that the home's expectation is when a resident has an injury that requires treatment, the treatment should be included on the Medication Administration Record (MAR) or TAR.

The licensee failed to ensure that its Skin and Wound policy #CARE12-010.05 is complied with specifically related to entering a treatment on the Treatment Administration Record (TAR/eTAR) for resident #001, specifically related to injuries sustained. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the licensee's policy #CARE3-P10 related to their Dementia Care Program was complied with in managing responsive

behaviours involving resident #001.

O. Reg. 79/10, r. 53. (1) requires the licensee to ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Review of the licensee's Dementia Care policy #CARE3-P10 (page 1 and 2) by Inspector #570 related to Dementia Care Program – effective date: August 31, 2016, directs:
Standard:
- Residents with dementia will be supported to maintain their autonomy, self-determination, and ability to participate in decision- making while recognizing their individual strengths, despite the severity of the disease.
- Residents with dementia will have a safe and supportive living environment that fosters relationship-based, rather that task-based staff approaches.
- Residents with dementia will be recognized as an individual with past lived experiences, relationships and the ability to make choices.
- Staff will partner with Residents with dementia and their family caregivers to support flexible caregiving approaches.
- Each home supports a safe environment that allows the Resident to move about freely.
Tools:
4. STOP aggressive Responsive Behaviours – Tool/Poster
S= STOP – Stop what you are doing. Stop the activity and step away from the situation to prevent/minimize escalation of aggression, and ensure the safety of those in the immediate area, including the resident.

A review of the clinical health records for resident #001 indicated the resident was admitted to the home on an identified date and time, with multiple diagnosis that includes Dementia.

A review of a Head to Toe assessment record for resident #001, dated January,

2017, at an identified time, by Inspector #607, indicated that the resident was assessed after returning from hospital on the same day, and several areas of skin impairments were identified.

In February, 2017, interview with RN #107 indicated to Inspectors #570 and #607, that resident #001 sometimes refuses her care and this became worse in the last few months. The RN further indicated when resident #001 refuses care, the expectation is staff leave the resident, and go back when suitable; notify the charge nurse, and family members will be notified as well. If the resident gets agitated or says no, staff cannot and should not force him/her to do anything that he/she does not want to, as the resident is able to communicate to staff care needs.

In February, 2017, interview with PSW #109 and #110 indicated to Inspectors #570 and #607, that resident #001 is a late sleeper; if the resident did not want to get up, staff were to leave him/her and re-approach at a later time; when resident #001 refuses to get up, the Registered Nurse or the Charge Nurse will be informed; staff are to continue to re-approach the resident, and sometimes he/she gets up on his/her own. PSW #109 and #110 further indicated if any resident becomes aggressive, staff are to leave the resident and report this to the Charge Nurse; re-approach the resident in about 15- 30 minutes with another staff; if re-approaching does not work, leave the resident and re-approach with another staff member.

In February, 2017, interview with the DOC indicated to Inspectors #570 and #607, it is an expectation that when staff approach a resident to provide care, and the resident is resistive, agitated or refuses care, the staff should leave the resident, and notify the Charge Nurse; later the staff should approach the resident with another staff member to provide care. The DOC further indicated that PSW #114 did not follow the STOP approach intervention, included in the licensee's policy #CARE3-P10, when he/she continued to provide care for resident #001 and the resident was resistive. The DOC indicated the PSW should have notified the Charge Nurse when the resident was first found to be resistive to care, and should have had another staff to assist with care when the resident was re-approached.

The licensee failed to ensure it's #CARE3-P10 policy in relation to responsive behaviours was complied with, specific to implementing the STOP tool in managing the responsive behaviour for resident #001, resulting in the resident sustaining multiple injuries to his/her body parts. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was based on at a minimum, interdisciplinary assessment with respect to sleep patterns and preferences.

Resident #001 was admitted to the home on an identified date, with multiple diagnosis that includes Dementia.

In January, 2017, the resident sustained an injury while being provided care at an identified time.

Review of the Licensee's investigation notes into the incident of alleged physical abuse in January, 2017, indicated PSW #114 went back at an identified time and informed the resident it was passed the time that he/she had to get up.

In February, 2017, interviews with RN #111 and PSWs #109 and #110 indicated to Inspectors #570 and #607, that the resident does not like to get up for breakfast, likes to sleep in, and the resident gets up whenever he/she is ready. All staff interviewed indicated when the resident refuses to get up, or refuses care, they will leave and re-approach at a later time.

In January, 2017, interview with RN #107 indicated that resident #001 does not have a specific time to go to bed. The RN further indicated that PSWs will have the resident ready for bed by an identified time, and the resident sometimes will tell staff when he/she is ready to go to bed.

In January, 2017, interview with PSW #101 indicated that resident #001 can go to bed by their self, and that sometimes the resident goes to bed around at an identified time. The PSW further indicated that he/she was not aware of any preferred time for resident #001's bedtime, and the resident goes to bed whenever he/she feels like it.

Review of the plans of care in place since admission and current plan of care for resident #001, indicated the resident's sleep pattern and preferences were not included in the plan of care until January, 2017, following the incident that occurred in January, 2017, with directions to staff to re-approach until the resident gets up on his/her own and that the resident prefers to sleep until wakens naturally.

In February, 2017, during interviews with the DOC and RN #106 by Inspectors #570 and #607, both indicated to the Inspectors that resident #001's sleep patterns and preferences were not included in the resident's plan of care until after the incident occurring in January, 2017.

The licensee failed to ensure the plan of care for resident #001 was based on interdisciplinary assessment with respect to sleep patterns and preferences specific to not including interventions related to when the resident awakens, until after an incident in January, 2017, and the resident's bedtime. [s. 26. (3) 21.]

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 has failed to ensure that the behavioural triggers were identified for resident #001 in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's responsive behaviours.

Record review of resident #001's clinical health records by Inspector #570, indicated that resident #001 was admitted to the home on an identified date, with multiple diagnosis that includes Dementia.

Review of progress notes for resident #001 for a seven month period, indicated the resident had exhibited multiple responsive behaviours.

Observations of resident #001 during the inspection indicated the resident is cognitively well, and ambulates independently around the unit with no mobility aid. No responsive behaviours were noted during the inspection.

In February, 2017, interview with RN #107 indicated to Inspectors #570 and #607, that resident #001 sometimes refuses his/her care, and this behaviour became worse in the last few months. The RN further indicated when resident #001 refuses care, the expectation is staff are to leave the resident and go back when suitable, notify the Charge Nurse, and the family will be notified as well. The RN also indicated, if the resident gets agitated or says no, staff cannot and should not force the resident to do anything that he/she does not want to do, as the resident is able to communicate his/her care needs.

In February, 2017, interview with RN #111 indicated to Inspectors #570 and #607, that resident #001 had not presented any responsive behaviours other than refusing to get out of bed. The RN further indicated if a resident was resistive to care; Personal Support Worker (PSW) staff had to report it to the Registered staff; have two PSWs to assist the resident; leave the resident and come back at a later time; or have other PSWs assist the resident and/or RNs are to assess the resident for an as needed (PRN) medication to help manage the resident's behaviour.

In February, 2017, interview with PSW #102 indicated to Inspectors #570 and #607, that when resident #001 gets upset, it is usually because he/she wants to go home, and often states that a family member is waiting for him/her. The PSW further indicated if it is too loud, on the unit, or if there is confrontation by other residents, resident #001 does not want be around these residents. The PSW also indicated that he/she has noticed the resident once swearing and yelling, wanting to leave and go home, and indicated he/she was not aware of any triggers to the resident’s behaviours.

In February, 2017, interview with RN #106 indicated to Inspectors #570 and #607, that resident #001 sometimes exhibits responsive behaviours that includes looking for family members and staff wanting to hurt him/her; sometimes agitated towards resident and further indicated the agitation is the main behaviour. The RN further indicated the triggers for resident #001’s responsive behaviours include: when the resident talks about family, friends, and kids from school, then staff know the resident would become agitated and they would redirect the resident to be involved in programs, take her for a walk or offering her coffee. The RN also indicated that if resident #001 has an altercation with other residents they would separate them and monitor the resident.

In February, 2017, during an interview, the DOC indicated to Inspectors #570 and #607, that he/she is the lead of the BSO team, and the only trigger that was identified for resident #001's identified responsive behaviours is the resident exhibits delusional thoughts. The DOC further indicated that no other triggers or strategies were identified in the plan of care to manage resident #001’s aggressive behaviours directed towards other residents, or other responsive behaviours exhibited.

A review of resident #001's written plan of care, by Inspector #570, updated January, 2017, and in place at the time of the above identified incident related to

responsive behaviours indicated: physical aggression towards residents and occasionally to staff when approach for care, triggered by delusional thinking due to Cognitive impairment/Dementia. The resident had several behavioural interventions in place.

Review of the information included on the white board of the unit that directs the PSWs how to manage resident #001's identified responsive behaviours indicated resident #001 exhibited several responsive behaviours and nursing interventions. The information displayed on the white board which is a part of resident #001's plan of care, did not include information indicating trigger's for the resident's behaviours, or the interventions that direct the PSWs how to manage resident #001's identified responsive behaviours.

The planned care for resident #001 did not identify responsive behaviours, nor was the residents plan of care revised to indicate all these responsive behaviours or related triggers. The only strategy/intervention that was added was in January, 2017, directing staff to re-approach resident and inform nurse when resident is exhibiting responsive behaviours, and this intervention was not added until after the January, 2017, incident, despite the resident continuing to demonstrate ongoing responsive behaviours.

The licensee failed to ensure that when resident #001 demonstrated ongoing responsive behaviours towards multiple vulnerable residents and self, the behavioural triggers were not identified and strategies were not developed and implemented to respond to the responsive behaviours. [s. 53. (4) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident's #001's SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that:resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

In an interview with resident #001's SDM in January and February, 2017, by Inspector #607, it was indicated that in January 2017, Registered Nurse (RN) #106 had contacted the SDM and informed the SDM that resident #001, had sustained an injury to a body part and will be transferred to the hospital for further assessment and treatments. The SDM indicated, that RN #106 was asked how the resident sustained the injuries and there were no answers from the RN. The SDM further indicated that he/she had gone to see resident #001 at the hospital, after speaking with RN #106. Upon arrival at the hospital, the SDM indicated that he/she had observed resident #001 dressed in a long sleeve turtle neck top and did not notice any injuries to the resident. However, he/she had observed bandages on the resident's body parts. The SDM indicated that the attending Physician informed him/her at that time, that there were injuries to resident #001's body part. The SDM further indicated that the resident informed him/her that he/she did not know how the injuries were acquired, but indicated that a staff member had hurt him/her. The resident was discharged from hospital and returned to the home later that day. The SDM indicated upon arrival to the home, he/she

had asked staff how the resident received the injuries, and no one at the home was able to give him/her an answer, nor was he/she notified at this point that an investigation was being conducted into the incident. The SDM further indicated, that he/she had asked a family member to go by the home to see resident #001 in January 2017, and further indicated that after the family member arrived at the home, the family member had contacted him/her and asked him/her to come and see resident #001, as multiple injuries were noted to the resident's body. The SDM indicated, upon arrival at the home, he/she observed resident #001 to have multiple injuries to his/her body. At which time, he/she took pictures, went to see the police, and later informed the Ministry of Health and Long-Term Care. The SDM indicated, he/she had visited the home once again, in January 2017. During her visit, the Director of Care approached him/her, they had a meeting, and it was at that time, the DOC had informed his/her that an investigation had been initiated, regarding the above identified incident, and further informed him/her that PSW #114 was relieved from duty, pending investigations. This was 72 hours later after the incident.

A review of a Head to Toe assessment record for resident #001, dated January, 2017, at an identified time, indicated that the resident was assessed after returning from hospital and had multiple skin impairments to his/her body. Further review of resident #001's clinical health care records failed to locate documented evidence indicating the Substitute Decision Maker (SDM) of the resident was notified of the identified skin impairments.

In an interview with RN #106 in February, 2017, by Inspectors #570 and #607, the RN indicated that he/she did contact resident #001's SDM in January, 2017, and had only informed the SDM that resident #001 had sustained injuries to the residents body part and was being transferred to the hospital for further assessments and treatments, as he/she was unsure of what else to say to the SDM.

In an Interview with PSW #102 in February, 2017, by Inspector #607 and #570, the PSW indicated that he/she had identified the skin impairments to resident #001's body in January, 2017, and had brought them to the RN #112's attention.

In an interview with RN #112 in February, 2017, by Inspector #607 and #570, the RN indicated that he/she had assessed resident # 001"s skin and noted the above identified skin impairments on two identified dates in January, 2017, but could not remember if he/she had notified the resident's SDM of the identified skin

impairments.

In an interview with the DOC in February, 2017, by Inspectors #570 and #607, the DOC indicated that he/she was waiting at the home on January, 2017, to speak with resident #001's SDM when he/she later learned that resident #001 and his/her SDM had gone out for dinner and so he/she went home and did not speak with the SDM until three days later, in January, 2017. The DOC further indicated that he/she had instructed RN #106 on the date of the incident in January, 2017, to contact resident #001's SDM to notify him/her of the residents injury, but was not sure what was communicated to the SDM by RN #106.

In a further interview with the DOC in February, 2017, by Inspector #607 and #570 indicated, it is the home's expectation that the SDMs of residents are notified when the staff discovered unexplained skin impairments to residents.

In an interview with the Administrator in February, 2017, by Inspectors #570 and #607, indicated that he/she was aware that resident #001's SDM was contacted in January, 2017, on the date the incident occurred, but was not aware of what was communicated. The Administrator further indicated that when there is an alleged abuse, it is home's expectation that the DOC or the Administrator contact the residents SDM and inform them of the alleged abuse and that an investigation is being conducted.

The licensee failed to ensure the resident SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, specifically related to resident #001. [s. 97. (1) (a)]

Issued on this 24 day of March 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

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

Inspection No. / No de l'inspection : 2017_397607_0001 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002087-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Mar 24, 2017;(A1)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
WINBOURNE PARK
1020 Westney Road North, AJAX, ON, L1T-4K6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : BEVERLEY RAYSIDE

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The Licensee shall implement a daily monitoring process over a two month period, using policy #CARE3-P10 as a framework, to ensure that all staff who provide care to residents with responsive behaviours

1. Demonstrate the ability to identify the most appropriate timing and approach to care, to enhance cooperation if and when residents are resistive to care;
2. Stop and step away from the situation to minimize or prevent the escalation of the behavior; and
3. Actively listen to residents who are resistive to care to understand each resident's current reality in order to better respond the underlying care needs, in consultation with registered nursing staff and other members of the healthcare team, as needed.

Staff education and/or re-instruction should be provided by the Licensee to address the knowledge and skills gaps identified during the monitoring period.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #001 was protected from Physical Abuse by Personal Support Worker #114.

Under O.Reg.79/10, s. 2(1), for the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Logs #002087-17 and #001904-17:

A Critical Incident Report was submitted to the Director in January, 2017, at an identified time, for an incident related to an alleged staff to resident physical abuse that occurred on an identified date and time. The CIR indicated that resident #001 was being care for by Personal Support Worker #114, when the resident became resistive to care, sustaining injuries to the resident body parts. A complaint was also submitted to the Ministry of Health and Long-Term Care in January 2017, at an identified time in regards to the above identified incident, indicating the Substitute Decision Maker (SDM) had not been informed of how the incident occurred, or that an investigation was being conducted by the home.

Record review of resident's #001 clinical health records by Inspector #570 and #607, indicated that resident #001 was admitted to the home on an identified date, with multiple diagnosis that includes Dementia.

Review of progress notes for resident #001 for the period of August, 2016, to February 2017, indicated the resident had exhibited multiple responsive behaviours.

In an interview with resident #001's SDM in January and February, 2017, by Inspector #607, it was indicated that in January 2017, Registered Nurse (RN) #106 had contacted the SDM and informed the SDM that resident #001, had sustained an injury to a body part and will be transferred to the hospital for further assessments and treatments. The SDM indicated that RN #106 was asked how the resident sustained the injuries and there were no answers from the RN. The SDM further indicated that he/she had gone to see resident #001 at the hospital, after speaking with RN #106. Upon arrival at the hospital, the SDM indicated that he/she had observed resident #001 dressed in a long sleeve turtle neck top and did not notice any injuries to the resident. However, he/she had observed bandages on the resident's body parts. The SDM indicated, that the attending Physician informed him/her at that time, that there were injuries to resident #001's body part. The SDM further indicated, that the resident informed him/her that he/she did not know how the

injuries were acquired, but indicated that a staff member had hurt him/her. The resident was discharged from hospital and returned to the home later. The SDM indicated, upon arrival to the home, he/she had asked staff how the resident had sustained the injuries, and no one at the home was able to give him/her an answer, nor was he/she notified at this point that an investigation was being conducted into the incident. The SDM further indicated, that he/she had asked a family member to go by the home to see resident #001 in January 2017 on another identified date, and further indicated that after the family member arrived at the home, the family member had contacted him/her and ask him/her to come and see resident #001, as multiple injuries were noted to the resident's body. The SDM indicated, upon arrival at the home, he/she observed resident #001 to have multiple injuries to his/her body parts. At which time, he/she took pictures, went to see the police and later informed the Ministry of Health and Long-Term Care. The SDM indicated, he/she had visited the home once again, on another identified date in January, 2017, and during his/her visit, the Director of Care approached him/her, they had a meeting, and it was at that time, the DOC had informed him/her that an investigation had been initiated, regarding the above identified incident and further informed him/her that PSW #114 was relieved from duty, pending investigations, this was 72 hours later, after the incident.

A review of a Head to Toe assessment record for resident #001, dated January 2017, at an identified time indicated that the resident was assessed after returning from hospital and multiple skin impairments were identified. Further review of resident #001's clinical health care records failed to locate documented evidence indicating the Substitute Decision Maker (SDM) of the resident was notified of the identified skin impairments.

In an interview with resident #001 in February 2017, by Inspectors #607 and #507 the resident indicated that a staff member had hurt him/her. The resident was unable to identify who the staff member was, but indicated that the staff member was seen before working on the unit, prior to the incident.

In an interview with RN #106 in February 2017, by Inspectors #607 and #507, indicated that on the date of the incident, the housekeeping staff #114 had informed him/her that resident #001 had an injury and needed help. RN#106 and RN student #105 went to the resident's room. Upon arrival, the resident was observed by RN #106 seated in a room with an injury to the resident's body part, while Personal Support Worker (PSW) #114 was observed standing next to the resident. The RN

indicated, that he/she observed multiple injuries to the resident The RN further indicated, that at this point, he/she had asked PSW #114 how the resident sustained the injuries, and the PSW indicated that the resident was resistive to care. The RN also indicated, that while speaking with PSW #114, the PSW was continuing to provide care to resident #001; when the resident asked the PSW not to touch him/her and pointed to the injury to his/her body part. The RN further indicated that it was at that point, he/she indicated to PSW #114 to stop providing care to the resident and indicated no further question was asked to the PSW. RN #106 indicated, he/she had asked RN student #105 to go and get the Director of Care (DOC), while he/she applied ice and a temporary dressing to resident #001's body part. During this time, the DOC arrived, assessed the resident, and had contacted the Physician from another floor to assess the resident. The resident was assessed by the Physician, who further indicated, that the resident required further treatment and ordered that resident #001 be sent out to the hospital for further assessments and treatments. RN #106 further indicated, that he/she contacted resident #001's SDM and had notified the SDM that the resident had sustained an injury and would be transferred to the hospital. The resident's attending physician was also notified, and the paramedics were contacted. The resident was later transferred to hospital for further assessments.

In an interview with RN student #105, by Inspectors #607 and #570 in February, 2017, the student confirmed the incident occurred the same as RN #106 described, but indicated witnessing resident #001 to be upset and had heard the resident telling PSW #114 "to stay away from him/her". The RN student further indicated that he/she was instructed by RN #106 to go get the DOC, which he/she did, and both the DOC and the Clinical Manager came to see resident #001.

In an interview with PSW #104, who was working at the time the incident occurred, by Inspectors #607 and #570 in February, 2017, the PSW indicated that resident #001 requires limited assistance with care. PSW #104 indicated that at no time during the shift did PSW #114 had indicated to him/her that resident #001 had refused or was resistive to care. PSW #104 further indicated, that he/she had gone in to see the resident when he/she learned of the incident, and had observed resident #001 seated in a room, while RN #106 was applying ice to the resident's body part. PSW #104 indicated the resident was visibly upset, and was shouting at PSW #114 to get away from him/her.

In an interview with RN #112 and PSW #102 by Inspectors #607 and #570 in

February, 2017, both indicated that resident #001 was assessed upon returning from hospital on January, 2017, and confirmed the above identified injuries.

In an email received by Inspector #607, in February, 2017, at an identified time from a Detective from Durham Regional Police, the Detective indicated that PSW #114 was arrested and charged with assault causing bodily harm.

1. The licensee's policy #CARE3-P10 in relation to responsive behaviours was not complied with, specific to implementing the STOP tool in managing the responsive behaviour for resident #001, resulting in the resident sustaining multiple injuries to the resident's body parts. The licensee also failed to ensure that it's Skin and Wound policy #CARE12-010.05 was complied with, specifically related to entering a treatment on the Treatment Administration Record (TAR/eTAR) for resident #001, specifically related to skin impairments to the residents body part, as identified under O. Reg. 79/10, s. 8. (1) (b), (Refer to WN #02).

2. The licensee failed to ensure the resident SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, specifically related to resident #001, as identified under O. Reg. 79/10, s.97 (1) (Refer to WN #05).

3. The Licensee failed to ensure that when resident #001 demonstrated ongoing verbal and physical aggression and other responsive behaviours, the behaviours triggers were not identified where possible, and strategies to manage the responsive behaviour were not developed and implemented where possible; nor were actions taken to respond to the resident needs including reassessment and interventions to the responses were documented, as identified under O. Reg. 79/10, s. 53 (4) (Refer to WN #04).

4. The licensee failed to ensure that the plan of care for resident #001 was based on interdisciplinary assessment with respect to sleep patterns and preferences, specific to not including interventions related to when the resident awakens, until after an incident in January, 2017, and the resident's bedtime, as identified under O. Reg.79/10, s. 26. (3) 21 (Refer to WN #03).

The licensee does not have a history of non-compliance with LTCHA, 2007 S.O.

2007, c 8, s.19, however, there was actual harm of physical abuse by PSW #114 directed towards resident #001, as evidenced by the licensee submitting a report to the Director, as identified under LTCHA, 2007, s. 24, conducted an investigation, as identified under LTCHA 2007, s. 23, taken action in response to the incident by relieving PSW #114 from duty pending investigations, later terminated the PSW and the PSW was subsequently charged with assault causing bodily harm on February 9, 2017, as identified under O. Reg. 104 (1). Based on the severity and the negative outcome experienced by resident #001 a Compliance Order was warranted. [s. 19. (1)] (607)

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

May 05, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 24 day of March 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JULIET MANDERSON-GRAY - (A1)

Service Area Office /
Bureau régional de services : Ottawa