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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2017	2017_414110_0010	021331-17	Resident Quality Inspection

Licensee/Titulaire de permis

SPENCER HOUSE INC.
835 West Ridge Blvd ORILLIA ON L3V 8B3

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

SPENCER HOUSE INC.
835 West Ridge Blvd. ORILLIA ON L3V 8B3

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

DIANE BROWN (110), JULIEANN HING (649), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6, 7, 8, 11, 12, 13, 14, 15,18, 19, 20, 21, 22, 25, 26, 27, 28, 29. October 2, 2017.

The following Critical Incidents (CI) were inspected:
Log #034317-16, related to an allegation of resident to resident abuse.
Log #007115-17, related to falls prevention and management.
Log #011182-17, related to falls prevention and management.
Log #015816-17, related to falls prevention and management.
Log #024526-16, related to a safe and secure home environment.
Log #021630-17, related to an allegation of resident to resident abuse.

The following complaints were inspected:
Log #026118-16 related to a safe and secure home environment.
Log #032558-16 related to a safe and secure home environment, emergency plans and falls prevention and management.
Log # 012389-17 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with Acting Executive Director and Executive Director, Medical Director, Director of Care, Associate Director of Care, Nurse Managers, Director for Resident Programs, Physiotherapist, Physiotherapist assistants, Recreation Aide, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

The home submitted a Critical Incident (CI) report on an identified date, indicating an incident that caused injury to resident #025 for which the resident had been taken to

hospital and resulted in a significant change in health status.

This incident was also referenced in two complaints submitted to the Ministry of Health and Long Term Care.

Record review of the 24 hour Nursing report, on an identified date, revealed under “environmental concerns” documentation of a service interruption in the home. Staff interviews with #106, #107, #110 #112 and #113 confirmed the service interruption.

Record review of the progress notes documented by RPN #107 revealed that it was reported to him/her that resident #025 had an identified accident during the service interruption and that the resident was transferred to the hospital where he/she was diagnosed with a significant change in status.

Interviews with staff #106 and #113, who witnessed the resident's accident, revealed the resident's unsafe environment at the time of the accident.

Interview with resident #025 revealed, his/her accident was as a result of an unexpected, unsafe environment and that she/he does not have the same mobility since the accident.

A review of the home's orientation package for PSW and RPN's supplied by the DOC failed to include orientation to emergency procedures, on what to do in the event of an identified service interruption.

Interview with the DOC confirmed, at the time of the service interruption, resident #025's environment was unsafe.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated.

A review of the home's compliance history revealed one or more unrelated non compliances in the last three years.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff

On identified date and time, the inspector observed resident #008 exhibit behaviours towards resident #007 in a public area of the home. The inspector immediately brought his/her observation to PSW #134's attention.

A review of resident #007's most current written care plan revealed there was no mention of any identified responsive behaviour with no interventions to direct staff how to manage this behaviour.

A review of resident #007's progress notes over a 21 month period revealed eight incidents of inappropriate responsive behaviours with residents #008, #009, #010, and #011.

According to resident #007's most recent quarterly MDS assessment, the resident had a CPS score indicating moderate impairment.

Residents #007, #008, #009, #010, and #011 were not interviewable.

A review of the home's policy titled Prevention of Abuse and Neglect of a Resident, #VII-G-10.00, current revision January 2015, did not indicate a process for determining capacity with cognitively impaired residents.

A review of resident #008's most recent quarterly MDS assessment, indicated that the resident has a CPS score indicating moderately impaired.

Interview with RPN #115 who had documented the incident between residents #007 and #008 on the observed date, revealed that he/she had documented that resident #007 seems to be happy but revealed to inspector that he/she had not witnessed the incident between the two residents.The RPN further revealed he/she was documenting what PSW #134 had observed and had reported to him/her. The RPN told the inspector he/she did not think of this incident was a form of abuse and revealed he/she had reported the incident to the nurse manager who was working on that day.

Interview with PSW #134 who had been informed by the inspector and witnessed the incident on the identified date, revealed that he/she had spoken with residents #007 and #008 and explained the inappropriate place for the behaviour and had removed resident #007 willingly to another identified area. According to PSW #134 neither resident #007 or #008 were capable of consenting. The PSW stated he/she had reported his/her observations to RPN #115 and told the inspector that he/she did not have a conversation with any of the residents at the time of the incident and did not suspect abuse at this time but should have.

Interview with PSW #138 in relation to another incident between residents #007 and resident #008, two months prior, revealed that he/she did not think of the described incident as abuse. According to the PSW, consent was implied because of the way the residents were behaving with each other. The PSW told the inspector that if the residents had been asked if they had consented to the behaviour they would understand and be able to answer yes or no, but stated this question had not been asked to the residents at the time of the incident.

Interview with the home's Medical Director who is also the residents' physician revealed that resident #007 has identified diagnoses and he/she indicated that the resident may not have insight and would not be able to give consent. According to the physician residents #008, 009, #010, and #011 do not have insight into their diagnoses and why they are at the home. Residents #010 and #011 were not able to make decisions on their own or consent to treatments. The physician stated residents #008, #009, and #011 can consent but would not have the capacity to understand right from wrong and resident #010 would not understand when someone else was not consenting. The physician further revealed that whether residents consent to behaviours or not it is the same as

consenting to taking medications. He/she further stated if it is not upsetting giving medications to the residents when they don't have the capacity to consent it therefore cannot be upsetting when the residents do not have the capacity to consent to other activities.

Interview with resident #007's POA #136 revealed that he/she visits resident #007 and sometimes the resident does not recognize him/her. According the POA the resident does not understand what is happening and when the POA mentions something to the resident ten seconds later the resident forgets. The POA told the inspector that he/she is aware that resident #007 has had some responsive behaviours with co-residents. The POA did not have full knowledge of resident #007's behaviours towards co-residents.

Interview with ADOC #124 confirmed that RPN #115 had reported the incident on an identified date, to him/her and told the inspector that this incident was consensual and both residents' families were aware. ADOC #124 revealed consent was implied based on the residents' response and reaction to the incident and both residents are cognitively impaired. A review of all of the above mentioned progress notes (except for one identified incident) documentation with the ADOC revealed that he/she had not recognized any of the above mentioned incidents as abuse.

According to the most recent MDS annual assessment, resident #011 had a CPS score indicating moderate impairment.

Interview with RPN #133 who had witnessed the above incident, with resident #007 and #011 indicated that consent had been implied by the manner in which the residents were behaving. The RPN revealed that he/she did not ask resident #011 if resident #007 had his/her permission to interact in the manner observed. According to the RPN he/she did not feel resident #007 was cognitively aware to ask resident #011's permission and resident #011 was cognitive enough to know what was happening at that moment and would not be able to recall the incident afterwards. The RPN further stated that neither resident is able to provide consent due to their cognitive status.

Interview with resident #011's POA revealed that he/she was aware that resident #011 was friendly with resident #007 but did not express awareness of all behaviours between the two residents.

Interview with the DOC confirmed that he/she had been informed of the incident on an identified date, between residents #007 and #011 and consent was implied by both

parties. The DOC told the inspector that he/she had not spoken with either resident and to his/her knowledge no one had asked the residents if either had consented to the observed activity. The DOC further revealed that lots of thought went into the decision if consensual or not and unfortunately very challenging with cognitively impaired residents as they do not always understand. According to the DOC he/she was not aware if the POA's of residents #007 and #011 had been notified of the incident, between the two residents.
According to the DOC the home does not have a policy to direct staff on how to obtain consent for the identified responsive behaviours among residents who are cognitively impaired and that they treat it the same as any other consent and inform the SDMs. The DOC stated that resident #007 and #011 do not have the ability to give consent but through their actions consent is implied.

Interview with Acting Executive Director (A-ED) #143 confirmed the home does not have an identified policy in place to assess capacity of residents in order to obtain consent prior to the identified activity. The A-ED revealed that currently consent has been obtained through observation and if the resident is able to say yes or no. The A-ED further revealed that consent to the identified activity among cognitively impaired residents would be based upon observations of the residents. According to the A-ED at this point if either resident is exhibiting any of these behaviours redirection will be provided.

The severity of the non-compliance showed a potential for actual/harm risk.

The scope of the non-compliance was widespread.

The Compliance History Report showed ongoing non-compliance with VPC in report

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

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

Review of an identified CI report revealed on an identified date and time, resident #017 was found lying by his/her bedside. The resident was noted to be experiencing symptoms related to his/her medical diagnosis at the time of the fall, and sustained no injuries. Later that shift, while RPN #104 was assisting a co-resident in his/her room and resident #017 was sitting in the wheelchair in hallway outside the room, RPN #104 was alerted to a loud noise. RPN #104 responded and found resident #017 lying on the floor. The resident sustained an injury and was taken to hospital.

Review of resident #017's plan of care, progress notes and post-fall assessments revealed the resident had both cognitive and physical impairments, and was at high risk for falls. The post-fall assessments indicated the resident's medical diagnosis was one of the factors contributing to the falls. Further review of the plan of care indicated no intervention was developed to direct staff how to monitor the resident and what care to be given to the resident when he/she is experiencing these identified symptoms.

Interviews with PSW #100 and #101 indicated when they observed the resident with symptoms of his/her diagnosis, they would report to the nurse. Sometimes the staff would keep the resident in an identified area for close monitoring, or the nurse might take

the resident down the hallway to keep an eye on him/her.

Interviews with RPN #102 and #103 indicated when resident #017 was experiencing symptoms related to his/her medical diagnosis, they would monitor the resident closely or occupy the resident with an activity. The staff members indicated the plan of care was not developed to set out how staff should monitor the resident and what intervention should be given to the resident when he/she was experiencing symptoms of his/her diagnosis.

Interview with the ADOC indicated resident #017's medical diagnosis has contributed to his/her risk for falls. The ADOC stated all staff should collaborate to develop the resident's fall prevention plan of care, and after the post-fall assessment, registered staff may implement any interventions that were required for preventing the falls. In the morning meeting every day, the ADOC will review all the falls in the last 24 hours with the team to follow up on the post fall assessments. The ADOC confirmed that the plan of care for managing the resident's medical diagnosis was not developed so that the care was integrated and was consistent with and complemented each other.

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

a. Review of an identified CI report revealed that on an identified date and time, resident #017 was found lying on the floor, but sustained no injuries. Later that shift, while RPN #104 was assisting a co-resident in his/her room and resident #017 was sitting in the wheelchair in hallway outside the room, RPN #104 was alerted to a loud noise. RPN #104 responded and found resident #017 lying on the floor, the resident sustained an injury and was taken to hospital.

Review of resident #017's plan of care and Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment revealed the resident had both cognitive and physical impairments, and required one-person assistance for transfer. Further review of the plan of care, progress notes and post-fall assessments revealed resident #017 was a high risk for falls, and had been using a device as one of the falls prevention interventions.

Review of the post-fall assessment and the progress notes indicated the night of the identified fall, there was no record of the fall prevention device in place at the time of the fall.

Interviews with PSW #100, #101, RPN #102, #103 and #104 indicated resident #017 was at high risk for falls. RPN #102 confirmed there was no record indicating the device was in place at the time of the fall.

Interview with RPN #104 confirmed that there was no fall prevention device in place for the resident at the time of the fall.
Interview with the ADOC indicated that at the time of the above mentioned fall, resident #017 should have had the device in place for falls prevention. The ADOC acknowledged that the device was not applied for resident #017 as specified in the plan of care.

b. On an identified date, the inspector observed resident #017 was lying in bed.

Review of resident #017's falls prevention plan of care revealed fall prevention interventions to be in place when the resident is in bed.

Interview with resident #017's family member who was present, confirmed awareness of the fall prevention interventions and that they were not place on this identified date during inspectors observations.

Interview with PSW #100 confirmed he/she put resident #017 in bed on the identified date and confirmed awareness of the resident's fall prevention interventions and that he/she had not implemented the interventions as required.

Interview with the ADOC acknowledged that staff are expected to follow the plan of care for resident #017 and implement the interventions when the resident is in bed but it they did not.

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 staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On identified date and time, the inspector observed resident #008 exhibit behaviours towards resident #007's in a public area of the home. The inspector immediately brought his/her observation to PSW #134's attention.

A review of resident #007's progress notes over a 21 month period revealed eight incidents of inappropriate responsive behaviours with residents #008, #009, #010, and #011.

A review of resident #007's most current written care plan revealed there was no

mentioned of any responsive behaviour and no interventions to direct staff how to manage this behaviour.

Resident #007was not interviewable.

Interview with PSW #134 revealed the kardex in PCC did not provide direction on how to manage resident #007's behaviour towards co-residents. The PSW stated that it should be there in the written plan of care especially since it is not the first time this behaviour has happen and it is a behaviour that resident #007 has.

Interview with RPN #133 revealed that resident #007's written plan of care does not provide direction to staff about what to do when resident #007 is witnessed exhibiting behaviours towards co-residents. The RPN revealed he/she was advised by a nurse manager that when there was an incident of between resident #007 and #011 to monitor the residents to ensure safety and redirect.

Interview with ADOC #124 revealed that resident #007's written plan of care did not identify strategies to guide direct care staff about what to do when resident #007 exhibits responsive behaviours with co-residents. According to the ADOC direction given to the front line staff when resident #007 is exhibiting this behaviour includes looking to see if the residents are comfortable and redirect away from each other.

Interview with the DOC revealed resident #007's written plan of care did not mention any responsive behaviour and would expect strategies to be mentioned in the plan of care.

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures.

Resident #003 triggered from stage one of the RQI for no activity of daily living (ADL) assistance related to dental care.

On an identified date and time resident's #003 teeth were observed unclean with yellowish discoloration between his/her upper front teeth. This observation was immediately brought to the attention of PSW #121 who took the resident to his/her room and cleaned his/her teeth removing the yellow discoloration between the resident's teeth using a green mouth swab without much success. The resident's electric toothbrush was used to remove the yellowish discoloration.

A review of resident #003's written plan of care, indicated under ADL self-care of oral care for one staff to assist and provide cuing with mouth care twice daily and as needed (PRN) and an electric toothbrush was provided.

A review of resident #003 dentist visit, indicated that an identified number of teeth on the upper arch require extraction.

Interview with PSW #121 revealed that he/she had cleaned resident #003's teeth the morning of the above observation and had used a green mouth swab instead of the resident's electric toothbrush. According to the PSW he/she mostly used a green mouth swab for cleaning of the resident's teeth as the resident bites down on the electric toothbrush and is not able to properly clean his/her teeth. The PSW revealed that he/she does not turn on the electric toothbrush as it frightens the resident. The PSW confirmed to the inspector that the resident's teeth had not been properly cleaned using a green mouth swab and had used the electric toothbrush to clean the resident's teeth properly that morning. The PSW stated that he/she does not think a green mouth swab cleans the resident teeth properly and the resident would benefit from a manual toothbrush.

Interview with PSW #101 revealed that resident #003 does not like the electric toothbrush and stated using the electric toothbrush without turning it on is not effective. The PSW revealed he/she got a manual toothbrush from the cart and the resident is more accepting of mouth care. According to the PSW resident #003 refuses to have his/her teeth brushed most evenings and he/she had not been reporting this concern to the nurse or may have mentioned it to a RPN who is currently on leave. According to the PSW resident #003 is more accepting of cleaning his/her teeth after receipt of his/her medications.

A review of resident #003 progress notes for the period of approximately seven months, did not indicate any documentation of the resident refusing to have his/her teeth brushed in the evenings.

Interview with the DOC revealed that it is the home's expectation that mouth care is provided twice a day and PRN and expects that if the resident has not been accepting oral care or is anxious to notify the charge nurse to update the care plan to use a manual toothbrush and stated that the mouth swabs should not be used as a replacement of a toothbrush.

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 each resident of the home received oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

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 has failed to ensure that 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.

Review of two identified CI reports revealed that on on an identified date and time, PSW #129 heard resident #018 shouting. Upon entering resident #018's room, PSW #129 saw resident #019 exhibit responsive behaviours towards resident #018 in resident #018's room. Resident #019's responsive behaviours resulted in resident #018 sustaining an injury.

Review of an identified CI report revealed that months later resident #020 was walking

towards an area where resident #019 was standing. When resident #020 walked around resident #019, resident #019 exhibited a responsive behaviour towards #020 resulting in resident #020 sustaining an injury. AA # 116 intervened and both resident were separated.

Review of progress notes and plans of care for resident #018, #019 and #020 revealed these residents had cognitive impairments. During a one year period, resident #019's progress notes revealed he/she had demonstrated ongoing responsive behaviours towards staff and/or residents including the two incidents that mentioned above.

Review of assessment records and behavioural plan of care for resident #019 indicated specialized resources were involved with the resident's responsive behaviours assessment over one year ago. The current plan of care implemented to manage the resident's behaviours included strategies to be used by staff when observing resident behaviours.

Interview with PSW #129, #130, AA #116, and RPN #133 indicated and described resident #019's responsive behaviours. The staff members indicated resident #019's behaviours had risk of altercation and harmful interactions towards other residents. One of the factors that could potentially trigger resident #019's was resident #020 and interactions between these two residents may happen without staff attention.The staff further indicated that there were no interventions or direction to prevent resident #019 from being triggered by resident #020.

PSW #130, AA #116, RPN #133 and the DOC acknowledged that the behavioural strategies were implemented to assist staff to be reactive to resident #019's responsive behaviours when staff were present. The staff member further acknowledged that no interventions were developed and implemented in resident #019's plans of care to minimize the risk of altercation with other residents, specifically between resident #019 and #020, when staff were not present.

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 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

During the lunch meal service on an identified day, activity aide (AA) #146 was observed sitting beside resident #026 and assisting the resident with eating.

The resident was positioned, while being fed, at an approximate 70 degree angle. The resident's chair was titled back along with resident's head. Resident #026 presented with his/her chin up and looking upwards towards the ceiling.

Interview with AA #146 confirmed the resident was not in a comfortable and safe feeding position and that nursing had been dealing with the resident's chair for months. Interview with RPN #115, present during the meal time observations, acknowledged that the resident's position was not appropriate. The RPN stated the chair would not tilt forward and that the occupational therapist was looking into other chairs. The RPN revealed he/she was unsure of what more he/she could do.

The AA #146 and RPN #115 confirmed that resident #026 was not safely positioned while being fed at lunch.

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 proper techniques used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received training in the area of emergency and evacuation procedures before performing their responsibilities.

This inspection was initiated related to an identified CI report, indicating an incident that caused injury to resident #025 for which the resident had been taken to hospital and resulted in a significant change in health status.

This incident was also referenced in two complaints submitted to the Ministry of Health and Long Term Care.

Record review of the 24 hour Nursing report, on an identified date, revealed under "environmental concerns" documentation of a service interruption in the home. Staff interviews with #106, #107, #110 #112 and #113 confirmed the service interruption.

Record review of the progress notes documented by RPN #107 revealed that it was

reported to him/her that resident #025 had an identified accident during the service interruption and the resident was transferred to the hospital where he/she was diagnosed with a significant change in status.

Interviews with staff #106 and #113, who witnessed the resident's accident, revealed the resident's unsafe environment at the time of the accident.

Interview with resident #025 revealed, his/her accident was as a result of an unexpected, unsafe environment and that she/he does not have the same mobility since the accident.

Interview with registered staff #107 who worked on resident #025's unit at the time of service interruption and resident #025's accident began employment in the home on 20 months prior. Staff #107 revealed that he/she did not recall being provided with education in the event this type of service interruption and stated he/she was unaware of the resources available to staff. When questioned what direction he/she would provide staff, on how to complete an identified task during the service interruption, registered staff #107 stated he/she would not know how to advise them and would refer to his/her nurse manager #110.

Interview with nurse manager #110, who worked at the time of the service interruption, was unsure how staff would perform an identified task. Nurse Manager confirmed that orientation was not provided on emergency procedures in the event of this type of service interruption.

An interview with ESM #111 revealed that he/she was made aware the following day of the service interruption in the home and the environment resulting in resident #025's accident. The ESM revealed that he/she had asked the DOC to remind staff at his/her next staff meeting of the emergency procedures during this type of service interruption. The ESM stated he/she assumed this information was provided to all staff during orientation.

A review of the home's orientation package for PSW and RPN's supplied by the DOC failed to include orientation to emergency procedures, on what to do in the event of the identified service interruption.

An interview with the DOC confirmed that all staff had not received training in the area of emergency procedures before performing their responsibilities. [s. 76. (2)]

2. Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

A review of five employee personnel files was conducted as a result of non-compliance related to abuse.

Record review of five employees personnel files revealed that employees #144 and #145 first day of employment at the long-term care home were on September 7, and August 12, 2017, respectively. According to the home's records provided to the inspector on October 2, 2017, they revealed that employees #144 and #145 had not completed the home's mandatory training on the abuse and neglect before the start of their employment.

Telephone interview with employee #144 on October 3, 2017, revealed that his/her first day of work had been on September 7, 2017, and he/she had just completed the mandatory training over the weekend. According to the employee he/she started the training on September 29, 2017, and had returned to the home the following day on September 30, 2017, to complete the training.

Telephone interview with employee #145 on October 3, 2017, revealed that his/her first day of work had been on August 12, 2017, and he/she had started the training on September 30, 2017, and completed it on October 1, 2017.

Interview with the A-ED revealed that employees #144 and #145 had not completed the required mandatory training prior to performing their responsibilities at the home.

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 all staff have received training in the area of emergency and evacuation procedures before performing their responsibilities, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the right of every resident to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, is fully respected and promoted.

Resident #003 triggered from stage one of the RQI for choices lacking related to his/her clothing.

Observations during stage one of the RQI and further observations during stage two, revealed resident #003's clothing was soiled.

Observation on an identified date, during the day shift, resident #003's clothing was observed to be soiled. Another observation on the same day, approximately 2.5 hours later, during the afternoon shift, resident's clothing was in the same soiled condition with more stains.

Interview with PSW #101 revealed the resident's family likes resident #003's clothing to be clean and have asked that if the resident's clothes are soiled to change his/her clothing at the end of the day shift. According to PSW #101 he/she had not received any report on this day that the resident had refused to have his/her clothing changed and told the inspector that the soiled clothing was from breakfast and lunch.

Interview with NM #119 revealed it is the home's expectation that the resident have clean clothing and should not have been left with dried food crumbs and food stains on his/her clothing.

Observation on another identified date and time resident #003's clothing was scattered with dried food spots.

Interview with PSW #106 revealed he/she had toileted the resident before breakfast as the resident has been dressed by the night staff. The PSW told inspector that he/she will get another staff to help change the resident and told inspector that the resident's clothing should absolutely not be left that way.

Interview with the DOC revealed it is the home's expectation that every resident should be clothed, groomed and cared for in a manner consistent with his/her needs.

WN #10: 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 :

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

The home's policy titled Falls Prevention #VII-G-30.00 with a revision date of January 2015, stated that each member of the interdisciplinary team will complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team.

This IP was initiated by a CI report related to resident #027's accident which resulted in a transfer to hospital with a diagnosis of a significant injury.

Record review of the resident's health record identified that resident #027 was at a moderate risk for falls and fall interventions were in place. Resident was transferred internally from one home area to another on an identified date. Record review identified that resident fell two days following the move and then again a day later. After the second fall on the identified date a referral was sent to the PT stating resident has had two falls close together since moving to a new unit.

Further record review identified that resident fell twice more after the referral was sent, and then again when he/she fell and sustained a significant injury. There was no evidence of a PT assessment during this time and prior to the resident's fall with significant injury.

Interview with PT #001 identified that he/she does receive referrals from nursing as part of the falls prevention program. The PT revealed that he/she prioritizes referrals and aims to complete an assessment of the resident within a couple of working days. The PT confirmed that he/she did not assess the resident following the referral as required by the home's policy and prior to the resident's fall with injury.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).

Findings/Faits saillants :

The licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, failed to make a report in writing to the Director setting out the names of any staff members or other persons who were present at or discovered the incident.

Review of CI, report on an identified date, reported an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The incident identified that resident #025 has an accident and sustained an injury.

Staff interviews revealed that a student and now PSW in the home, #106 was present, witnessed the resident's accident and recalled the circumstances surrounding the accident.

Review of the amended CI, revealed that student/ PSW #106's name was not included in the report.

Interview with the DOC revealed he/she was unaware that PSW #106 was present and had witnessed the resident's accident and that this individual's name was not disclosed during his/her investigation. The DOC confirmed that PSW #106 name was not included in the amended report.

Issued on this 29th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), JULIEANN HING (649), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2017_414110_0010
Log No. / No de registre :	021331-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 6, 2017
Licensee / Titulaire de permis :	SPENCER HOUSE INC. 835 West Ridge Blvd, ORILLIA, ON, L3V-8B3
LTC Home / Foyer de SLD :	SPENCER HOUSE INC. 835 West Ridge Blvd., ORILLIA, ON, L3V-8B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Traci VanGrinsven

To SPENCER HOUSE 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

1. The licensee shall provide education to all PSW and registered staff on the emergency procedures required during an identified service interruption.

2. Revise the home's orientation package to include direction to newly hired staff on procedures required during a service interruption.

3. A list of staff names and confirmation that education has been provided as required.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

The home submitted a Critical Incident (CI) report on an identified date, indicating an incident that caused injury to resident #025 for which the resident had been taken to hospital and resulted in a significant change in health status.

This incident was also referenced in two complaints submitted to the Ministry of Health and Long Term Care.

Record review of the 24 hour Nursing report, on an identified date, revealed under "environmental concerns" documentation of a service interruption in the home. Staff interviews with #106, #107, #110 #112 and #113 confirmed the service interruption.

Record review of the progress notes documented by RPN #107 revealed that it was reported to him/her that resident #025 had an identified accident during the

service interruption and that the resident was transferred to the hospital where he/she was diagnosed with a significant change in status.

Interviews with staff #106 and #113, who witnessed the resident's accident, revealed the resident's unsafe environment at the time of the accident.

Interview with resident #025 revealed, his/her accident was as a result of an unexpected, unsafe environment and that she/he does not have the same mobility since the accident.

A review of the home's orientation package for PSW and RPN's supplied by the DOC failed to include orientation to emergency procedures, on what to do in the event of an identified service interruption.

Interview with the DOC confirmed, at the time of the service interruption, resident #025's environment was unsafe.

The severity of the non-compliance was actual harm.

The scope of the non-compliance was isolated.

A review of the home's compliance history revealed one or more unrelated non compliances in the last three years.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining that the following requirements,1 -5 have been addressed.

1. Update the home's abuse policy to include the procedures for staff in assessing capacity and determining consent for all residents.

2. Educate staff on the home's updated abuse policy with a focus on recognizing abuse and the process of determining capacity and consent related to identified resident to resident interaction.

3. Develop and implement interventions for resident #007's identified responsive behavior to ensure residents are safe from his/her responsive behaviour.

4. Review resident #007 plan of care to include a focus, goal, and interventions to address resident #007 identified responsive behaviour and ensure staff are aware of the content of the plan.

5. Develop a process to monitor the interventions that have been developed for resident #007 to ensure they have been implemented.

The plan is to be emailed to JulieAnn.Hing@ontario.ca by November 15, 2017.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff.

On identified date and time, the inspector observed resident #008 exhibit

behaviours towards resident #007 in a public area of the home. The inspector immediately brought his/her observation to PSW #134's attention.

A review of resident #007's most current written care plan revealed there was no mention of any identified responsive behaviour with no interventions to direct staff how to manage this behaviour.

A review of resident #007's progress notes over a 21 month period revealed eight incidents of inappropriate responsive behaviours with residents #008, #009, #010, and #011.

According to resident #007's most recent quarterly MDS assessment, the resident had a CPS score indicating moderate impairment.

Residents #007, #008, #009, #010, and #011 were not interviewable.

A review of the home's policy titled Prevention of Abuse and Neglect of a Resident, #VII-G-10.00, current revision January 2015, did not indicate a process for determining capacity with cognitively impaired residents.

A review of resident #008's most recent quarterly MDS assessment, indicated that the resident has a CPS score indicating moderately impaired.

Interview with RPN #115 who had documented the incident between residents #007 and #008 on the observed date, revealed that he/she had documented that resident #007 seems to be happy but revealed to inspector that he/she had not witnessed the incident between the two residents.The RPN further revealed he/she was documenting what PSW #134 had observed and had reported to him/her. The RPN told the inspector he/she did not think of this incident was a form of abuse and revealed he/she had reported the incident to the nurse manager who was working on that day.

Interview with PSW #134 who had been informed by the inspector and witnessed the incident on the identified date, revealed that he/she had spoken with residents #007 and #008 and explained the inappropriate place for the behaviour and had removed resident #007 willingly to another identified area. According to PSW #134 neither resident #007 or #008 were capable of consenting. The PSW stated he/she had reported his/her observations to RPN #115 and told the inspector that he/she did not have a conversation with any of

the residents at the time of the incident and did not suspect abuse at this time but should have.

Interview with PSW #138 in relation to another incident between residents #007 and resident #008, two months prior, revealed that he/she did not think of the described incident as abuse. According to the PSW, consent was implied because of the way the residents were behaving with each other. The PSW told the inspector that if the residents had been asked if they had consented to the behaviour they would understand and be able to answer yes or no, but stated this question had not been asked to the residents at the time of the incident.

Interview with the home's Medical Director who is also the residents' physician revealed that resident #007 has identified diagnoses and he/she indicated that the resident may not have insight and would not be able to give consent. According to the physician residents #008, 009, #010, and #011 do not have insight into their diagnoses and why they are at the home. Residents #010 and #011 were not able to make decisions on their own or consent to treatments. The physician stated residents #008, #009, and #011 can consent but would not have the capacity to understand right from wrong and resident #010 would not understand when someone else was not consenting. The physician further revealed that whether residents consent to behaviours or not it is the same as consenting to taking medications. He/she further stated if it is not upsetting giving medications to the residents when they don't have the capacity to consent it therefore cannot be upsetting when the residents do not have the capacity to consent to other activities.

Interview with resident #007's POA #136 revealed that he/she visits resident #007 and sometimes the resident does not recognize him/her. According the POA the resident does not understand what is happening and when the POA mentions something to the resident ten seconds later the resident forgets. The POA told the inspector that he/she is aware that resident #007 has had some responsive behaviours with co-residents. The POA did not have full knowledge of resident #007's behaviours towards co-residents.

Interview with ADOC #124 confirmed that RPN #115 had reported the incident on an identified date, to him/her and told the inspector that this incident was consensual and both residents' families were aware. ADOC #124 revealed consent was implied based on the residents' response and reaction to the incident and both residents are cognitively impaired. A review of all of the above

mentioned progress notes (except for one identified incident) documentation with the ADOC revealed that he/she had not recognized any of the above mentioned incidents as abuse.

According to the most recent MDS annual assessment, resident #011 had a CPS score indicating moderate impairment.

Interview with RPN #133 who had witnessed the above incident, with resident #007 and #011 indicated that consent had been implied by the manner in which the residents were behaving. The RPN revealed that he/she did not ask resident #011 if resident #007 had his/her permission to interact in the manner observed. According to the RPN he/she did not feel resident #007 was cognitively aware to ask resident #011's permission and resident #011 was cognitive enough to know what was happening at that moment and would not be able to recall the incident afterwards. The RPN further stated that neither resident is able to provide consent due to their cognitive status.

Interview with resident #011's POA revealed that he/she was aware that resident #011 was friendly with resident #007 but did not express awareness of all behaviours between the two residents.

Interview with the DOC confirmed that he/she had been informed of the incident on an identified date, between residents #007 and #011 and consent was implied by both parties. The DOC told the inspector that he/she had not spoken with either resident and to his/her knowledge no one had asked the residents if either had consented to the observed activity. The DOC further revealed that lots of thought went into the decision if consensual or not and unfortunately very challenging with cognitively impaired residents as they do not always understand. According to the DOC he/she was not aware if the POA's of residents #007 and #011 had been notified of the incident, between the two residents.
According to the DOC the home does not have a policy to direct staff on how to obtain consent for the identified responsive behaviours among residents who are cognitively impaired and that they treat it the same as any other consent and inform the SDMs. The DOC stated that resident #007 and #011 do not have the ability to give consent but through their actions consent is implied.

Interview with Acting Executive Director (A-ED) #143 confirmed the home does not have an identified policy in place to assess capacity of residents in order to

obtain consent prior to the identified activity. The A-ED revealed that currently consent has been obtained through observation and if the resident is able to say yes or no. The A-ED further revealed that consent to the identified activity among cognitively impaired residents would be based upon observations of the residents. According to the A-ED at this point if either resident is exhibiting any of these behaviours redirection will be provided.

The severity of the non-compliance showed a potential for actual/harm risk.

The scope of the non-compliance was widespread.

The Compliance History Report showed ongoing non-compliance with VPC in report

(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 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, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 6th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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