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 sions de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2016	2016_349590_0006	005530-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

The Village at St.Clair
1800 Talbot Road WINDSOR ON 000 000

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144), HELENE DESABRAIS (615), NANCY SINCLAIR (537), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 24, 25, 26, 29, March 1, 2, 3, 4, 7, 8, 9, 10, 11 & 14, 2016.

The following Critical Incidents were inspected concurrently:

Log #023414-15/CIS #3046-000160-15
Log #025328-15/CIS #3046-000165-15

Log #026955-15/CIS #3046-000170-15
Log #026957-15/CIS #3046-000173-15
Log #028958-15/CIS #3046-000178-15 & 3046-000188-15
Log #028972-15/CIS #3046-000179-15
Log #031204-15/CIS #3046-000182-15
Log #013311-15/CIS #3046-000130-15
Log #034303-15/CIS #3046-000189-15
Log #034333-15/CIS #3046-000191-15
Log #035340-15/CIS #3046-000192-15
Log #001765-15/CIS #3046-000004-15
Log #032461-15/CIS #3046-000185-15
Log #032466-15/CIS #3046-000184-15

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing Care, two Assistant Directors of Nursing Care, two Neighbourhood Co-ordinators, the Recreation Director, the Dietary Supervisor, the Registered Dietitian, the Chaplain, one Registered Nurse (RN), 13 Registered Practical Nurses (RPN), 15 Personal Care Aides (PCA), one Ward Clerk, the Family Council President, the Resident Council President, three Family members and 40+ Residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, relevant policies related to inspection, internal investigation notes, Critical Incident System reports, Resident Council meeting minutes and Family Council meeting minutes.

During the course of the inspection, the inspector(s) observed all resident home areas, dining services, medication rooms and medication administration, the provision of resident care, recreational activities, resident/staff interactions, resident/resident interactions, infection control practices and posting of required information.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of resident #004’s progress notes for an eight month time period, revealed that the resident exhibited several behaviours which affected other resident's and/or staff members on at least 46 occasions during this time.

A review of resident #004’s progress notes for the eight month time period revealed:

A Behavioural Supports Ontario (BSO) document revealed an initial assessment was completed to address identified responsive behaviours. Interventions were identified to assist the staff in managing the resident's behaviour's, however was ineffective or not trialed according to follow up documentation from the BSO team, two and four months after the initial assessment.

Resident #004's paper chart revealed that the resident was discharged from the BSO Team five months after the initial assessment, “reason for discharge: Stabilized”, however records reviewed indicated the resident's responsive behaviours continued.

A second initial BSO assessment was completed for identified responsive behaviours, at least eight months after the resident initially began exhibiting these behaviours. Interventions were identified and implemented at that time.

A review of the home's policy titled "Personal Expression Program using The Layered Natured Framework and The P.I.E.C.E.S Approach", dated February 17, 2015, stated:

"Procedure. Level of risk. Potential risk: The Neighbourhood Team Leader/Designate will:

1. Contact their Neighbourhood Co-ordinator and Physician to discuss the reason for the referral. NOTE: The Neighbourhood Co-ordinator/Designate at this time initiates a conversation with the Resident's Substitute Decision Maker (SDM) regarding an update on the resident's status and/or the need for a referral to the Villages' Personal Expression Resource Team (PE-Resource Team).
2. Send a referral (if agreed upon by the Neighbourhood Co-ordinator/Physician) to the PE-Resource Team and discuss with the DNC/Designate to determine if 1:1 should be initiated.
3. Initiate assessments as discussed with the Neighbourhood Physician/Designate and the PE-Resource Team."

In an interview with resident #001 they indicated that they were fearful of resident #004 as a result of a previous incident involving resident #004 where resident #001 sustained an injury from their altercation. The inspector also spoke with resident #001's family member who indicated that they remained frightened of resident #004.

The inspector observed resident #004 to exhibit a specific behaviour throughout the Resident Quality Inspection (RQI).

In an interview with the ADNC #115 and Neighbourhood Co-ordinator #116, they shared that they were leads for the Personal Expressions Team and that resident #004 was monitored for responsive behaviours and expressions. They confirmed that the identified behaviours were increasing with time and the resident was a potential risk to other residents. They confirmed that the staff did not always complete referrals to the PE-Resource Team for assessment as cited in the home's policy "Personal Expression Program using The Layered Natured Framework and The P.I.E.C.E.S. Approach" and that for resident #004 a referral should have been submitted to address the resident's increasing behaviours and to prevent altercations with other residents.

In an interview with the General Manager #109, she confirmed that resident #004 had increased behaviours that were missed and that they should have been dealt with earlier. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Observations of resident #003's bed rails were completed during stage 1 of the RQI and revealed bed rails were being utilized.

In an interview with PCA #129 and RPN #130 and a review of the resident's clinical records revealed that bed rails were used as a Personal Assistive Services Device (PASD) for the resident.

Review of resident #003's documentation revealed that no individualized resident assessment had been completed to determine the need for the bed rails, the resident's/SDM preference, individualized safety risks with the use of bed rails and what purpose the bed rails were used for.

In an interview with RAI Co-ordinator #131, they stated that the home was discussing the process of bed rail assessments for residents that used them and could not provide documentation to support that residents, who used bed rails, had been assessed.

The General Manager #109 and the DNC #103 confirmed that residents who used bed rails had not been assessed. They confirmed that all the bed systems used in the home had been assessed for the specific zones of entrapment and that only individualized resident assessments had not all been completed. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 had failed to ensure that the responsive behaviour program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

In an interview with the ADNC #115 on March 7, 2016, she confirmed that the home had not completed any responsive behaviour program evaluations since the home opened. She did explain that the home has been making improvements to their personal expression program, such as the internal PE-Resource Team which was developed and had just been implemented this month. She shared that the homes staff members

involved in personal expressions would be completing a program evaluation planned for later this month. She confirmed that the homes programs should be evaluated annually to monitor for improvements. [s. 53. (3) (b)]

2. The licensee had failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Review of resident #045's progress notes revealed the resident was exhibiting personal expressions and that the BSO team was notified two days later. Interventions for safety and management of these behaviours, including Daily Observation Sheet (DOS) documentation was initiated by the staff. Another progress note dated 25 days later, indicated that another BSO referral had been sent for the same personal expressions.

Review of resident #045's progress notes, assessments and paper documentation on March 3, 2016, revealed that the BSO team had not yet seen this resident.

In an interview with the ADNC #115 on March 3, 2016, she explained the referral process of the homes internal PE-Resource Team and external BSO team. The staff are to complete an internal PE-Resource Team form and submit these to their Neighbourhood Co-ordinators for management on the unit. The ADNC was the person responsible for initiating external referrals to BSO or Geriatric Mental Health Outreach Team (GMHOT) when behaviours cannot be managed in the home by the staff with current interventions. The ADNC was not aware of the referral and could not explain why this resident's referral had not been completed in her absence.

In an interview with the ADNC #115 she confirmed that the staff member had used wrong terminology while documenting. She shared that she had spoken with the referring staff member and this resident's Neighbourhood Co-ordinator after our discussion. The staff member had completed the internal PE-Resource Team form as per policy, not a BSO referral, and placed it into the Neighbourhood Co-ordinators mailbox. The Neighbourhood Co-ordinator had been away at the time the referral was placed in her mailbox, however shared with the ADNC that she had not received a referral for this resident in her mailbox when she returned. The ADNC had also been away during this time and was not aware of the referral. The ADNC confirmed that the PE-Resource Team referral had been sent today.

Review of resident #045's DOS documentation, for a time period of a week, revealed that

documentation was incomplete for 21% of the required entries.

In the interview with ADNC #115 she confirmed that the homes expectations were that DOS documentation was completed, and that the resident's behaviour referral to the homes internal PE-Resource Team should have been assessed in a more timely manner in their absences. [s. 53. (4) (c)]

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 responsive behaviour program is being evaluated annually and updated in accordance with evidence-based practices or prevailing practices, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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 had failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Resident #046 was on a scheduled toileting plan to maintain urinary continence. The resident required assistance from one staff member to help complete the task of toileting.

Review of the CIS report related to this concern with the General Manager #109 revealed this resident was found to be in a brief saturated with urine on two days in a specific month. The management staff completed an investigation as required and found that there were some missing documentation on the toileting schedule during the times that the resident was found wet. Interventions were put in place.
Again, the next month after, the resident was found in a saturated brief twice. The home made an attempt to rectify the situation and implemented further interventions. The family also provided an intervention for the staff to use as they felt the resident was refusing assistance with toileting due to the staff's approach.

Review of the flowsheets for a time period of three months, revealed the following:

For one of the three months there were 60 times documentation was missing of 348 entries
For one of the three months there were 63 times documentation was missing of 372 entries
For one of the three months there were 56 times documentation was missing of 346 entries

Interview with PCA #133 revealed the staff were to sign the flowsheet when the resident has been toileted. The PCA indicated that if there was no signature for the allotted time period the staff either forgot to sign it or they did not toilet the resident. The PCA confirmed that the expectation was that all staff sign the flowsheet and document the appropriate intervention provided, including refusals of care.

In an interview with the General Manager #109 she indicated that the homes expectation is that the toileting habits flowsheets are documented on each time the resident was assisted or has refused the care. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee had failed to ensure that Residents' Council advice related to concerns or recommendations was responded to in writing within 10 days.

A review of the Resident Council and Food Committee Meeting Minutes from 2015 to current date revealed that concerns related to food services including meals being "unidentifiable", chaotic and delayed breakfast service, chipped cups and mugs, inconsistency with the delivery of the evening snack cart, etc. were documented in the meeting minutes.

Interviews with Recreation Director #125 & Dietary Supervisor #138 indicated that follow up occurred at the next meeting and was reflected in the meeting minutes. Recreation Director #125 also indicated that any follow up conducted through email with another manager was attached to meeting minutes and was date stamped, but was unsure if this was communicated to council until the next meeting.

A review of the home's policy and procedure Residents' Council Meeting Facilitation under guidelines stated:

"7. The Director of Recreation or Residents' Council Assistant will supply the General Manager with a copy of the Residents' Council meeting minutes each month. The General Manager or designate will be responsible for replying in writing to the resident's concerns or recommendations within 10 days of receiving the meeting minutes by using a Residents' Council Response Feedback Form."

During an interview with a representative from Resident Council, the resident was unsure if concerns or recommendations were followed up in writing within 10 days, however felt that the council was run well and that the council assistant provided follow up at the next meeting as needed.

General Manager #109 verified the home's expectation that all concerns or recommendations from Residents' Council should be followed up in writing within 10 days utilizing the Response Feedback Form identified in the home's policy. [s. 57. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that the Family Council advice related to concerns or recommendations was responded to in writing within 10 days.

A review of the Family Council meeting minutes from 2015 to current date revealed concerns related to smoking issues identified in the August 12, 2015, meeting minutes that "2nd hand smoke entering the building" and outstanding questions/ideas/suggestions related to cable rates. The December 16, 2015, minutes indicated that staff would "report back for the January meeting."

An interview with staff member #124 revealed that follow up occurred at the next meeting and should be reflected in the meeting minutes.

An interview with family council member #140 revealed that he was unsure if the council had ever received written follow up to concerns or recommendations within 10 days, that most follow up occurred at the next meeting and some issues remain on-going.

A review of the home's policy and procedure Family Council Purpose and Guidelines stated:

Family Council members may advise and report any concerns or recommendations to the General Manager. In turn the General Manager must respond in writing within 10 days.

Staff member #109 verified the home's expectation that all concerns or recommendations from Family Council should be followed up in writing within 10 days. [s. 60. (2)]

Issued on this 31st day of March, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144), HELENE DESABRAIS (615), NANCY SINCLAIR (537), TERRI DALY (115)
Inspection No. / No de l'inspection :	2016_349590_0006
Log No. / Registre no:	005530-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 24, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village at St.Clair 1800 Talbot Road, WINDSOR, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie Roy

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.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 for achieving compliance with LTCHA, 2007, c.8, s. 19 (1). The plan must include:

1. The Licensee's plan for addressing responsive behaviours for resident #004. Identify what changes and improvements are required to prevent further incidents of resident to resident abuse occurring involving residents with a pattern of aggressive behaviour.

2. What immediate and long term actions would be implemented for any resident exhibiting responsive behaviours that pose a risk to other resident's and/or staff members.

3. Education of the home's policy titled "Personal Expression Program using The Layered Natured Framework and The P.I.E.C.E.S Approach" is provided to all staff members.

Please submit the plan in writing to Alicia Marlatt Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Long Term Care Homes Inspection Division 130 Dufferin Avenue 4th Floor London Ontario N6A 5R2, by email alicia.marlatt@ontario.ca by May 31, 2016.

Grounds / Motifs :

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

A review of resident #004's progress notes for an eight month time period, revealed that the resident exhibited several behaviours which affected other

resident's and/or staff members on at least 46 occasions during this time.

A review of resident #004's progress notes for the eight month time period revealed:

A Behavioural Supports Ontario (BSO) document revealed an initial assessment was completed to address identified responsive behaviours. Interventions were identified to assist the staff in managing the resident's behaviour's, however was ineffective or not trialed according to follow up documentation from the BSO team, two and four months after the initial assessment.

Resident #004's paper chart revealed that the resident was discharged from the BSO Team five months after the initial assessment, "reason for discharge: Stabilized", however records reviewed indicated the resident's responsive behaviours continued.

A second initial BSO assessment was completed for identified responsive behaviours, at least eight months after the resident initially began exhibiting these behaviours. Interventions were identified and implemented at that time.

A review of the home's policy titled "Personal Expression Program using The Layered Natured Framework and The P.I.E.C.E.S Approach", dated February 17, 2015, stated:

"Procedure. Level of risk. Potential risk: The Neighbourhood Team Leader/Designate will:

1. Contact their Neighbourhood Co-ordinator and Physician to discuss the reason for the referral. NOTE: The Neighbourhood Co-ordinator/Designate at this time initiates a conversation with the Resident's Substitute Decision Maker (SDM) regarding an update on the resident's status and/or the need for a referral to the Villages' Personal Expression Resource Team (PE-Resource Team).
2. Send a referral (if agreed upon by the Neighbourhood Co-ordinator/Physician) to the PE-Resource Team and discuss with the DNC/Designate to determine if 1:1 should be initiated.
3. Initiate assessments as discussed with the Neighbourhood Physician/Designate and the PE-Resource Team."

In an interview with resident #001 they indicated that they were fearful of

resident #004 as a result of a previous incident involving resident #004 where resident #001 sustained an injury from their altercation. The inspector also spoke with resident #001's family member who indicated that they remained frightened of resident #004.

The inspector observed resident #004 to exhibit a specific behaviour throughout the Resident Quality Inspection (RQI).

In an interview with the ADNC #115 and Neighbourhood Co-ordinator #116, they shared that they were leads for the Personal Expressions Team and that resident #004 was monitored for responsive behaviours and expressions. They confirmed that the identified behaviours were increasing with time and the resident was a potential risk to other residents. They confirmed that the staff did not always complete referrals to the PE-Resource Team for assessment as cited in the home's policy "Personal Expression Program using The Layered Natured Framework and The P.I.E.C.E.S. Approach" and that for resident #004 a referral should have been submitted to address the resident's increasing behaviours and to prevent altercations with other residents.

In an interview with the General Manager #109, she confirmed that resident #004 had increased behaviours that were missed and that they should have been dealt with earlier. [s. 19. (1)]

The progress notes reviewed indicated that resident #004 has unmanaged verbal and physical behaviours which have affected numerous residents in the home making this a widespread issue. The severity of risk was determined by the fact that resident #004 had caused actual harm to other residents and remains a potential risk for harming other residents. The home has no previous non-compliance related to this specific area of legislation. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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

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 sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 24th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alicia Marlatt

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