Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2016	2016_270531_0001	031622-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

SUSAN DONNAN (531), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), KELLY BURNS (554), LYNDA BROWN (111)

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): January 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2016.

The following logs were completed concurrently with this inspection:
Log # 006441-15 and #000606-16 (falls)
Log # 011772-15 (alleged abuse)
Log #003479-15, 009733-15 and 031467-15 (care and services)
Log # 008736-15 (follow up)

During the course of the inspection, the inspector(s) spoke with Residents, Residents' family members, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the RAI Coordinator, Housekeeping Aides, the Dietary Manager, the Dietitian, the Environmental Supervisor, the Admissions Coordinator/environmental manager assistant,Activation Staff, Administrative staff, the Physiotherapist, the Assistant Director of Care, the Social Worker, the Resident and Family Council Presidents, the Director of Care and the Administrator.
During the course of the inspection, the inspectors conducted a full walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, the home's documented complaint record, the home's staffing schedules for the nursing department and the home's staffing plan.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **17 WN(s)**
- **4 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. 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 comply with LTCHA, 2007, s. 19 (1), by not ensuring Resident #045 was protected from abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening,insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Related to Intake #011772-15, for Resident #045:

Resident #045 has a cognitive impairment, and relies on staff for all activities of daily living.

Progress notes, for resident #045, were reviewed for a period of approximately six months. The progress notes provide details of five separate incidents in which Personal Support Workers and Registered Nursing Staff witnessed or suspected abuse of resident #045 by Family #046. Progress notes detail Family #046 yelling, swearing, forcefully shaking Resident #045's bed (with him/her in it) and force feeding the resident. The reviewed progress notes, provide details of resident #045 telling his/her family to "stop feeding him/her", indicating "I've had enough"; the progress notes indicate family continued to feed resident despite pleas to stop. Progress notes indicated that Family #046 was told, by Personal Support Workers and Registered Nursing Staff, that his/her actions were abusive and that the police could be called, in which Family #046 indicated, if I don't make resident #045 eat, he/she is going to starve.

Progress notes reviewed, for a specific date, failed to provide documentation that Registered Practical Nurse #126 reported a witnessed incident of resident #045 to the RN-Charge Nurse.

During interviews, with the inspector, RN-Charge Nurse #125 indicated that the Assistant Director of Care and the Social Worker were told of the incidents of suspected and or witnessed abuse of resident #045 by Family #046. RN-Charge Nurse #125 indicted that the incidents of abuse of resident #045 were not reported to the Director (MOHLTC) or to

the police.

The Assistant Director of Care (ADOC) indicated being aware of the family to resident abuse incident, which occurred on a specific date, and which was reported to him/her by RN #125. ADOC indicated reporting the incident to the Director of Care. Assistant Director of Care indicated that yelling, swearing and force feeding of a resident could be seen as abusive, but it was believed by the Director of Care and the Social Worker that Family #046 was merely not coping with the change in resident #045's condition. ADOC indicated not speaking with the resident about the incident. ADOC indicated that the incident, which was reported to him/her was not reported to the Director (MOHLTC).

On an identified date, Family #046 was heard by PSW #123 yelling and swearing at resident #045. PSW entered resident's room and found Family #046 forcefully shaking resident's bed (with resident in it) and heard yelling "I'm going to shake the hell out of you so you wake you". Family #046 was told by PSW #123 his/her actions were abusive and that if he/she didn't stop the police would be called. PSW #123 reported the witnessed abuse to RPN #124.

Registered Practical Nurse #124 indicated that he/she did not go down to resident #045's room to assess the resident, as PSW #123 did not indicate resident was in any danger. RPN #124 indicated he/she did not speak with Family #046 as to the witnessed incident. Registered Practical Nurse #124 indicated he/she did not report the witnessed abuse incident to the Director (MOHLTC) or to the police, as he/she had reported the incident, on the date to which it occurred, to the Director of Care.

The Director of Care acknowledged awareness of the fifth incident involving Family #046 and Resident #045, but indicated not being made aware of the incident until the day after the incident occurred.

Director of Care indicated that a meeting, involving herself, the Acting Administrator, Social Worker and the Dietitian was held with Family #046 to address the fifth incident and at that time Family #046 was told that his/her interaction with resident #045 was abusive. Director of Care indicated that the Acting Administrator and the Social Worker reminded Family #046 of the home's zero tolerance of abuse policy and the home's requirement to report abuse.

Director of Care indicated that incident (fifth incident) was not reported to the Director (Ministry of Health and Long-Term Care) as the decision by the administrative team was

to handle the incident in house. Director of Care indicated being told by the Acting Administrator "not to report the abuse incident to the Ministry of Health and Long-Term Care or the police".

The Director of Care indicated that during meeting with Family #046, he/she (family #046) indicated to the administrative team, that "he/she and resident #045 always talked to each other that way, when resident was well". The Director of Care confirmed that Resident #045 was cognitively impaired and was not able to defend self from others. Director of Care indicated "Family #046 was not coping with Resident #045's overall decline and such may have been affecting his/her behaviour".

The Director of Care indicated that she and other members of the nursing management team (Assistant Director of Care, and Clinical Coordinator) review home's progress notes on a daily basis; Director of Care indicated no awareness of the other incidents of alleged or witnessed abuse of resident #045 by Family #046, which were said to have occurred during a six month period.

Director Care and Administrator indicated that yelling, swearing, force feeding of a resident or shaking a resident's bed with resident in it would be considered abusive in nature.

During a second interview, the Director of Care indicated (to the inspector) that she was aware of the concerns of several nursing staff (personal support workers and registered nursing staff) specific to the alleged or witnessed abuse of resident #045, but that she and other managers were told by the Acting Administrator not to call the police and to handle the incidents in house. Director of Care indicated that in hindsight the incidents should have been reported as per the home's policy (Resident Abuse by Persons Other Than Staff).

The Acting Administrator was unavailable for an interview as he/she no longer employed by this home.

The Administrator indicated that it is an expectation that alleged, suspected or witnessed abuse it to be immediately reported to the Administrator, Director of Care and or designate (management or charge nurse). Administrator further indicated that abuse is to be immediately reported as per the legislative requirements.

Administrator indicated that all staff are expected to follow the home's policy and

procedures as it relates to "zero tolerance of abuse".

The licensee further failed to comply with the following:

- Under LTCHA, 2007, s. 24 (1) 2 - A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically, abuse of a resident by anyone that resulted in harm or a risk of harm to the resident. (as indicated by Written Notification #10)

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

- Under LTCHA, 2007, s 6 (1) – Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specific to verbal and emotional abuse of resident #045. (as indicated by Written Notification #3)

- Under LTCHA, s. 76 (4) - Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. Under subsection (2) all staff to receive annual training specific, to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports. (as indicated by Written Notification #13)

- Under O. Reg. 79/10, s. 98 - Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. (as indicated by Written Notification#15)

Scope and severity Summary:
Over a seven month period, there were five documented incidents of alleged, witnessed and or suspected abuse of resident #045, by Family #046 which caused the resident significant emotional distress where the resident was overheard pleading with the family member to stop.

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. Related to log # 008736-15:
The licensee did not ensure that the lighting requirements set out in the lighting table

were maintained.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "In all other areas of the home". A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in various locations in the home. While using this light meter, the operating error of < 10% was used to determine adequate lighting levels. The meter was held a standard 30 inches above and parallel to the floor. Lighting conditions were clear and sunny day outdoors at the time of the inspection and in order to prevent natural light from affecting indoor measurements all efforts were made to control the natural light. Window coverings were drawn in resident bedrooms, lounges and dining rooms tested, lights were turned on 5 minutes prior to measuring and doors were closed where possible (i.e. corridors). Areas that could not be tested due to natural light infiltration included the area in TV lounges directly in front of windows due to no window coverings available and end of corridors.

For this follow-up inspection, several resident bedrooms, resident washrooms, tub and shower rooms, 1st, 2nd and 3rd floor dining rooms, all corridors/lounges on each floor, were measured to determine current lighting levels. The areas below were found to be non-compliant with the lighting table:

Corridors/dining rooms/lounges:

January, 11, 2016
First floor:
-there are two long corridors and one short corridor (leading to front offices). The two long corridors had ceiling mounted fluorescent tube lights (troffer lights) as well as a ceiling mounted, semi-flush large circular fixture with opaque lens with compact fluorescent lights down the centre ceiling of the hallway spaced approx. 6 feet apart. All doors were closed and lights were turned on. Several of the ceiling mounted circular lights had a large amount of dead flies noted inside the fixtures. The ends of the long corridors and in front of the nursing station were affected by the natural light and therefore, not measured due to large windows where no curtains were available to close off natural light.
-the small TV lounge was measured with a reading of 110 lux with all lights turned on.
-the corridor starting at room 109: outside of room 109 and directly under the ceiling mounted, semi flushed large circular fixtures the light had a reading of 160 lux. Between the circular fixture lights the reading was 100 lux.Outside of room 106 & 107,directly under the dome light, had a reading of 62 lux.

-the small corridor entering the dining room had 2 chandelier lights which were turned on. The door entering the smaller dining room was also closed. The area in front of the public washroom in this same small corridor was 105 lux. The main dining room lighting was greater than 215.28 lux.
-the activity lounge lighting was also greater than 215.28 lux.

January 12, 2016:
2nd floor:
-there are two long corridors separated by the TV lounge, nursing station and elevator connecting the two, as well as one short corridor (leading to the dining room). The long corridors have approximately 1-2 feet diameter ceiling mounted, semi-flushed circular fixture with opaque lens with compact fluorescent lights down the centre spaced approximately 8 feet apart and the short corridor the ceiling mounted semi-flushed circular lights are spaced approximately 4-6 feet apart. All doors were closed and lights turned on. It was an overcast day.
-the corridor starting from room 240: from room 240 to 247 had light readings of 180 -190 lux directly under the lights and light reading ranging from 60-120 lux in between the ceiling mounted circular lights; from room 249-258 had light readings greater than 215 lux but this was affected by the natural light at end of the hallway.
-the TV lounge had 8 large semi-flush circular fixtures with an opaque lens spaced approximately 4-6 feet apart that were turned on and two large windows at end of TV lounge that had no curtains to remove all natural light. The area directly in front of the elevator had a reading of 115 lux. The area in front of the nursing station had a reading of approximately 160 lux. Approximately 10 feet from the window (close to the large post in the centre of the TV lounge) had a light reading of 180 lux (with natural lighting affecting the reading from the large windows).
-the corridor from rooms 201 to 219 had 10 large ceiling mounted circular lights spaced approximately 8 feet apart. Outside of room 201 had a reading of 115-120 lux. between room 204 & 205 had a reading of 130-135 lux, between room 206 & 207 had a reading of 55 lux directly under the circular light, between room 207 & 209 directly under the circular fixture light had a reading of approximately 90 lux, the small corridor in front of the bath/shower room (with light turned on) had a reading of 85 lux, the corridor from room 211-217 had reading of 140-160 lux.
-the short corridor from rooms 231 to 236 had ceiling mounted semi-flush circular fixtures with an opaque lens lights spaced approximately 4-6 feet apart. Outside of room 232 had reading of 120-130 lux, and outside of room 236 had reading of 170-175 lux.

3rd floor:

-the long corridor from rooms 340 to 358 had 9 large ceiling mounted, semi- flush circular fixtures with opaque lens with compact fluorescent lights down centre of ceiling spaced approximately 8-10 feet apart. This corridor had a large window at the end of the hall that did not have a curtain to remove natural light. The light reading between the lights ranged from approximately 60-180 lux; outside of room 349 and directly under the large circular fixture light had a reading of 140 lux.
-the TV lounge had 8 large ceiling mounted, semi-flush large circular fixture with opaque lens with compact fluorescent lights spaced approximately 8 feet apart and had 2 large windows with no curtains available to remove all natural light. One of the ceiling mounted semi-flush circular lights was burned out (closer to the nursing station) and had a reading of 80 to 110 lux. The areas closest to the elevator had a reading of 130 lux and in the middle of the TV lounge had a reading of 170 lux.
-the dining room had 11 chandelier lights and 5 scone lights. All windows had curtains closed to remove all natural light. Majority of the dining room had readings greater than 215 lux except between tables 8, 9 & 11 where the reading was only 170 lux and in front of the servery where the reading was 115 lux.
-the short corridor (outside of dining room) with rooms 334 to 350 had 4 large ceiling mounted semi-flush circular fixtures with opaque lens with compact fluorescent lens, the lights spaced approximately 8 feet apart. Outside of room 334 had a reading of 55 lux, between rooms 331 & 332 had a reading of 100 lux, in front of the MDS work station (placed in the same corridor) and directly under the light had a reading of 140 lux.
-the long corridor starting at room 301 had large ceiling mounted semi-flush circular fixtures with an opaque lens with fluorescent lights spaced approximately 10 feet apart. There was a large window at the end of this corridor and no curtain to remove all natural light. All lights were turned on and resident's doors closed. Between room 304 & 305 had a reading of 135 lux,
-the tub room had a large fluorescent light fixture directly above the tub. Between the sink and toilet had a reading of 50-80 lux but directly under the tub had a reading greater than 215 lux.

Resident rooms:
-most of the resident rooms in this home are semi private with two beds. There is one private room at the end of each long corridor on each floor and a 4 bed basic room, just before the dining rooms on the 2nd and 3rd floors only. All of the resident rooms have a wall mounted compact fluorescent over-bed lights and one ceiling mounted small circular light fixture with an opaque lens over the sink area. The bathrooms had one large ballast fluorescent light and all the bathrooms indicated light readings of greater than 215 lux.
-room 255 was a semi private with two beds with 2 compact fluorescent over bed lights

and one small circular fluorescent light over the sink area. All lights were turned on, with door and windows closed. In front of bed 1 (closest to the door) had light reading of 95-120 lux from door to beside the bed, greater than 215 lux at head of the bed directly under over bed lights, 95 lux directly under small round light at sink, 125 lux between bed 1 & 2, 75 lux standing directly in front the closet of bed 2 and end of bed 2.
-room 253 was a semi private with two beds and had all available lights turned on for greater than 10 minutes, with all door and window coverings closed. Bed 1& bed 2 had light readings of greater than 215 lux directly under the over bed light and at the head of the beds, bed 1 had a reading of 115 lux at the bedside, 85-90 lux in front of the sink and directly under the small circular light fixture, reading of 95-100 lux between bed 1 & 2, and 65-70 lux and the end of bed 2 and in front of the closet.
-room 251 was a semi private with two beds and all available lights turned on for greater than 10 minutes, with all door and window coverings closed. Both bed 1 & 2 had light readings of greater than 215 lux directly under the over bed lighting and at the head of the beds. Bed 2 had reading of 55-60 lux at the end of the bed and in front of the closet, 135-140 lux between bed 1 & 2, 75-80 lux under the sink, and 90-95 lux at entrance of room in front of bed 1.
-room 218 private room had one over bed light and a small circular light fixture over the sink. The door and curtains were closed and all lights turned on. The entrance of the room and in front of bathroom had a reading of 30 lux, 95 lux at the bedside, 75-80 lux in front of the sink and directly under the light fixture and in front of the closet, the area directly over the bed had a reading of greater than 215 lux.
-room 247 was a semi private room with two beds, an over bed light above each bed and a small circular light above the sink, the light reading was 50-60 lux at the entrance of the room and the bedside of bed 1, 155 lux directly under the sink and small light fixture, 35 lux in front of the closet and end of bed for bed 2, and 50 lux between bed 1 & 2. The lighting was adequate at the head of each bed under the over bed lights.
-room 355 was a semi private room with compact fluorescent lights in the over-bed lights and one small circular light above the sink area. All lights were turned on and curtains and door was closed. The entrance of the room and in front of the bathroom had a reading of 60 lux, the reading between bed 1 & 2 was 185 lux, directly under the sink was 90 lux, at end of bed 2 and in front of the closet was 80 lux

Discussions were held with the administrator and maintenance manager on January 11, 2015 during the inspection regarding the status of the lighting upgrade plan after a tour of the home was completed. Interview of the full-time maintenance stated he was unavailable for an interviewed. A request for an alternate day and time to be interviewed was not provided. Interview of Administrator indicated the home received a quote in April

2015 by the company Neolumens (provided by corporate) to complete the work. The Administrator indicated she was on leave from the home from April to October, 2015 and none of the work had been completed. The Administrator indicated that a second quote was received in December 2015 by the same company to complete the work. The Administrator indicated the second quote still required approval by corporate so to date, "none of the lighting upgrades has been completed ".

The minimum required amount of 215.28 lux was not achieved in all areas of the home, as specifically identified above. This continuing pattern of non-compliance requires that the compliance order be reissued. Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents.Insufficient lighting may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents, including to conduct assessments and to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutrition intake and overall quality of life. [s. 18.]

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1), by not ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident specially as it relates to verbal and emotional abuse.

Resident #045 is dependent on staff for activities of daily living.

The clinical health record, for resident #045, was reviewed (by the inspector) for a period of six months; progress notes provide documentation of five incidents of alleged or witnessed (verbal and emotional) abuse towards resident #045 by Family #046.

According to progress notes (for the period above) the Acting Administrator, Director of Care, Social Worker, Physician and Registered Nursing Staff were aware of incidents in which Family #046 was suspected or witnessed to be abusing (verbally, emotionally) resident #045.

The written plan of care was reviewed for resident #045, for the six month period; the written plan of care did not reflect strategies or interventions providing directions to staff specific to monitoring the family member when feeding the resident, family visits or emotional support to protect resident #045 from Family #046. [s. 6. (1)]

2. The licensee failed to comply with the LTCH Act 2007, c. 8, s.6 (1)(c) to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #007's current Care Plan indicated no instructions or interventions for oral or dental care on initial review on January 6, 2016. The Care Plan was revised on January 7, 2016 to include a section of Dental Status but did not indicate specific frequency of oral care.

In an interview with Resident #007 on a specified date, the resident #007 indicated that staff provided oral care once daily but the resident would prefer to have oral care done twice daily.

Resident #007 current plan of care indicated that the resident required extensive assistance with care needs. The care plan did not provide instructions or interventions for oral or dental care.

On a particular date during an interview with PSW # 112 she told inspector #626 that the resident is assisted with oral care in the morning by staff handing the resident the supplies. The resident sometimes refuses oral care; staff provide assistance to brush the resident's teeth, if the resident is unable.

The same day PSW # 114 indicated that the resident brushes his/her own teeth on evenings.
In an interview with RPN # 113 and review of the resident's care plan it was confirmed that there were no instructions or information provided regarding resident #007's oral or dental care and that PSWs assist the resident with oral care when the resident allows.

On January 11, 2016 RN #128 confirmed that resident #007 Care Plan was revised on January 7, 2016 to include a new Dental Status section which outlines that the resident's teeth/denture/mouth care are to be provided twice a day. [s. 6. (1) (c)]

3. Related to Log #031467-15

Interviews with resident #043 and his/her SDM on a particular date they indicated that they had brought to the attention of the home that the resident likes knitting and the

home mentioned that they were going to get someone to assist the resident with this activity.

Review of the progress notes for a specified date documented by the activities programs manager, indicated that the resident's SDM states "SDM told the home about how resident #043 likes knitting." SDM states that "he/she brought in knitting supplies, however, resident #043 needs a reminder as to how to get started."

Interviews with activity aide #140 and the activities programs manager indicated that they were not aware that the resident likes knitting; the programs manager also indicated that if this had been communicated to her she would have indicated the resident's need for assistance with this activity in the resident's plan of care. [s. 6. (1) (c)] (607)

4. The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by not ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, specifically as it relates to bowel care management, and fluid intake and hydration.

Related to Resident #020:

Resident #020 has a history of chronic discomfort.

The registered nursing staff and physician notes for resident #020, were reviewed for a specific period of time, indicate that the resident has been experiencing constipation issues.

Registered Nurse #106 indicated (to the inspector) that resident #020 has problems with constipation and often requires registered nursing staff to administer "as needed" medications or to initiate resident's bowel protocol as per medical directives.

Physician's Orders (for the date specified) included the following:
- Laxative by mouth once daily at bedtime;
- Suppository rectally as needed;
- Laxative by mouth at bedtime as needed.

Medical Directives:
- oral laxative, if no BM (bowel movement) for three days give two tablets by mouth in the

morning as needed;
- a suppository, if oral ineffective on same day, give one suppository rectally at bedtime as needed;
- If no BM for four days, assess and give an enema,
- Call MD (physician) if no adequate results after enema or no BM in five days.

The plan of care (current plan of care) indicated the following:

- Eating/Swallowing - goals of care indicated as resident will maintain his/her independence to eat and drink; interventions include, encourage resident to eat in the unit dining room ; serve meal promptly so resident does not get up from the table; offer tray service or continental breakfast if resident #20 refuses to come to the dining room; monitor amount of food consumed on POC (point of care – homes electronic resident flow sheet records); supervision with set up.

- Nutritional Status, high nutritional risk related to underweight status, anemia – goals of care include, resident will maintain stable weight, resident will maintain good intake, resident will consume 1200 mL/day (10 glasses, each glass being 120 mL) of fluids; interventions include, monitor intake and report any changes in fluid intake over three days to the Registered Dietitian.

Resident #020's fluid intake records were reviewed for a period of sixteen days; the records indicated that of the sixteen days reviewed, thirteen of those days, Resident #020 consumed 360-960 ml, which according to the resident's plan of care would indicate resident #020 was not consuming the required fluid intake.

Registered Nurse #106, the Assistant Director of Care and the Registered Dietitian, all indicated (to the inspector) that the night shift registered nursing staff are to check nightly fluid intake records of all residents nightly to ensure residents are consuming the required fluid intake (as assessed by the Registered Dietitian) ; all indicated that if a resident had not consumed the required fluid intake for three consecutive days then a referral is to be forwarded to the Registered Dietitian to re-assess hydration (fluid intake) needs and make further recommendations, as per the home's Food and Fluid Monitoring policy (#RESI-05-02-05).

Point of Care (POC, the home's electronic resident flow sheet records) and the electronic medication administration record (eMAR) were reviewed for the specified period, specifically as it relates to resident #020's bowel elimination pattern and the

administration of physician ordered bowel care management medications (routine and "as needed") the following was noted:

-On more than one specified date- documentation indicated resident #020's bowel pattern was (to have a bowel movement) once every four days; and despite resident #020 not having had a bowel movement, physician's medication orders were inconsistently followed (resident did not receive the prescribed laxative or suppositories; there is no documentation to support Resident #020 was assessed nor was resident's physician notified when bowel medications ordered were not effective, or when resident continued to experience constipation.

-On more than one specified date- documentation indicated Resident #020's bowel pattern was (to have a bowel movement) once every three to eight days; and despite Resident #020 not having had a bowel movement, physician's medication orders were inconsistently followed (resident did not receive the prescribed laxative, suppositories of fleet enema; there is no documentation to support Resident #020 was assessed nor was resident's physician notified when bowel medications ordered were not effective, or when resident continued to experience constipation.

Registered Nurse #106, who is the charge nurse on the unit where Resident #020 resides, indicated (to the inspector) that registered nursing staff are required to assess a resident when a resident is experiencing constipation, and as per the physician's orders (bowel care management protocol) assess for impaction if resident has had no bowel movement in four days; RN indicated that the assessment is to be charted in the progress notes. RN #106 further indicated that if resident has had no bowel movement in five days then registered nursing staff are to contact the physician for further direction.

Registered Nurse #106 reviewed progress notes (with inspector), for resident #020, for the specified time period indicated that the physician should have been advised of resident's ongoing constipation so that other interventions could have been suggested; RN #106 indicated, that the progress notes do not show that resident #020 was assessed for impaction, when resident #20 did not have a bowel movement for four days (or more).

Registered Nurse #106 indicated that there was no evidence that a referral had been made to the Registered Dietitian specific to poor fluid intake and or ongoing constipation being experienced by Resident #020.

Registered Dietitian indicated (to the inspector) that she was not aware that resident #020 was not consuming his/her required fluid intake nor was she aware that resident #020 was experiencing problems with constipation. Registered Dietitian indicated that she had not had any communications from the registered nursing staff as to poor intake or constipation issues (of the resident) and had not received any referrals for resident indicating the need for re-assessment.

Assistant Director of Care further indicated that the physician and registered dietitian should have been advised that resident was experiencing constipation, so that dietary and medical interventions could have been reviewed and reassessed. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
a)There is a written plan to care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide care to the resident. 2007, c. 8, s. 6 (1).
b)When a resident is reassessed and the plan of care reviewed and revised if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCH Act 2007, c. 8, s. 15 (2) whereby the home, furnishings and equipment are not maintained in a safe condition and good state of repair.

The following observations were made during the course of the inspection and constitute potential risk related to resident safety:

First floor home area:
Common areas:
Heater near the nursing station had a small area where it was separated/detached from the wall.
Cupboard in kitchenette the exterior strapping/molding at the bottom of one door is peeling/lifting off
Chipped/scarred paint noted on the exterior door/ door frames of room 101 through to room 121.
The West corridor sitting area the legs of the two wing back chairs are splintered and chipped.
The trim and wall board detached from wall in the corridor beside Rm. 101
Bifold doors in the main floor dining area have a noticable 3x2 inch hole in the door.
Right lower corner of the bifold doors has detached and observed jutting outwards.

Resident rooms:
Rm 106 the sink steel outlet drain observed as being corroded and rusted.
Rm 110 the lower bathroom door frame observed heavily scarred exposing steel door frame.
-the sink outlet drain in the shared bathroom observed with finish eroded and rusted.
Rm 111 4 floor tiles in front of the window have lifted in the corners others with cracked corners and blackish debris build up along the seams of the tiles.
-the sink outlet drain observed to be corroding and finish worn.

Rm 114 the lower two feet of the wall to the right of the bathroom is heavily scarred , paint and dry wall ripped/torn away.
-heavy black marks along bathroom door were observed.
-the lower three feet of the interior bathroom door is scarred with heavy black marks.
-lower foot of the bedroom door frame the paint is chipped exposing corner steel bead.

Rm 119 the lower foot of the entrance door has multiple areas of chipped/scarred/gouged paint exposing the base of door.
- observed the sink outlet drain as heavily corroded and some rust.

Second floor home area:
Common areas:
West tub/shower room sink/vanity/storage area lower edge of the cupboard observed as being chipped splintered with a sharp edge.
Left corner edge leading into the tub area observed damaged with 6x3 inch rough, aged drywall plaster/mudded areas.

The lower foot of the entrance wall (bilaterally)to the elevators is heavily scarred, gouged with wood pieces missing/splintered.

Second floor nurses' station the desk corners/edges are chipped, worn, leaving sharp splintered edges.

East corridor the tub/ shower room the lower left wall door frames door missing exposing steel bead. The sink cabinet/vanity observed heavily scarred and splintered.
Baseboard heater (12' L x 8" height)observed heavily scarred, gouged and paint missing/peeling/splintered along the entire heater exposing 3-4 different layers of paint.

The left lower wall in the east corridor next to room 253 is heavily scarred, gouged and chipped.
The corridors on both the second and third home units are cluttered with , lifts, wheelchairs fans and laundry carts obstructing the hand rails.

Resident rooms:
Rm 201 - the door frame noticeably chipped/scarred
Rm 202 the walls observed noticably scuffed in areas of room
- Door Frames observed as being chipped/scarred.
-The flooring tiles observed the tie joint spaces with dark grout visible between tiles.
- the caulking surrounding the sink observed being cracked.

Rm 204 three feet of the left lower wall observed with heavy scarring, corners broken and lower shelf beside the sink has a 3x2 inch chip wood missing with sharp jagged edge protruding.
Rm 206 lower clothes closet drawers observed chipped with jagged sharp corners.

Rm 221 the interior /exterior door frames door frames are scarred.
Rm 231 the sink outlet drain observed the finish as being corroded.
Rm 232 the left lower wall observed drywall as heavily scarred/gouged.
-the entire lower 3 feet of the wall the drywall observed as scarred.
Rm 235 Wall by the sink observed cracked along wall edges.
the sink outlet drain rusted
-Door frames noticably chipped/scarred.

Rm 236 floor tile in front of the bathroom the corners were observed cracked with pieces missing
-left lower wall the corner foot is damaged, trim is broken with detached edges, drywall is gouged and broken exposing steel corner bead.
-bathroom door frame is heavily scarred exposing steel corner bead
-floor trim to the right of the bathroom door observed as detached from wall.
-bathroom and bedroom floor joining floor tiles are cracked
-the sink outlet drain is corroded
-sink counter/vanity top observed having whitened discoloured marks?bleach marks.
- joints along tile flooring are open with black debris (dirt)
-multiple black scuff marks/discoloured tiles (resembling worn tile pattern.)
-the lower foot of the bedroom door frame the paint is chipped/scarred exposing corner steel bead
Rm 241 Wall in bathroom by handrail observed cracked and lifting.
Rm 242 Door - frame chipped
Rm 246 Wall - damage dry wall exposed and paint removed/chipped/scarred by the window
-the wall paint chipped and gouged in areas of room.
-door frames - chipped/scarred.
Sink observed with a small chip and the outlet drain observed rusted.
Rm 247 CTV (counter/vanity) laminate surround the (porous surface)observed being chipped.
-the sink outlet drain rusted.
-Door Frames - chippped/scarred.
-Walls identified with visible drywall repair/patched rough, aged and unfinished.
Rm 249 door and door frames chipped.
-the flooring by washroom- duct taped
-the walls - scuffed and chipped in bathroom.
-lower foot of the bedroom door frame the paint is chipped exposing corner steel bead
Rm 255 Wall - cracked along edge of CTV by sink, sink outlet drain observed with rust.

Door Frame - paint gouged and chipped.
Rm 256 lower 2 feet of the door frame the paint is damaged exposing wooden base on the right side.
- the left lower wall next to the bathroom the lower 3 feet observed as heavily scarred, paint removed and the door kick plate has detached (5x6")with the top right corner jutting out at waist level.
-outer edge of the sink drain is rusted

Third floor home area:
Common areas:
Storage closet door next to room 302 lower ft is heavily scarred, gouged, paint scraped.
Elevator door frames chipped gouged both lower 1-1/2 feet on both sides of the elevators.
Right wall in the east corridor between Rm 344-342 there are 6 unfinished/aged drywall rough patches ranging from 6x6 inches to 1x1 inches in size.
East tub and shower room lower walls are heavily scarred and gouged exposing steel frames for approx. the lower 10 inches.
- 10-12 foot long x 7 inches height, electric baseboard heater the paint has peeled, gouged, chipped along the entire heater exposing 3-4 different colours of paint. far corner of the heater is rusted along the edge.

Resident rooms:
Rm 311 Paint chips on the wall near the door.

Rm 330 The bathroom door has paint chips and dark marks along the bottom of the door. The wall next to the bathroom is chipped/scarred.

Rm 334 clothes closet chip board worn broken with sharp edges along the bottom and outer side of the left closet door.
Floor trim to the left of the sink area, the corners are cracked, chipped, heavily scarred with black matted/ patches resembling aged glue.

Rm 336 multiple worn cracked broken floor tiles across the width of the room. Some of the flooring tiles have been patched with ill fitting pieces and aged glue like substance. Multiple black discoloured marks on the tile floor? tile floor pattern has worn to base of tile.
Floor trim left corner broken/ detached/indented.

Rm. 355 two flooring tiles on both sides of the bed feet, with multiple small cut, blackened areas.
-corner tile by the resident's clothes closet chipped, lifted and piece missing.
-lower two feet of right wall the drywall damaged, gouged along the entire wall.
-top of bedside table chipped worn jagged/splintered edges exposing compressed board.

PSW #116, 118, 127 and 144 were interviewed on January 12, 2016 indicated that staff are responsible to document repairs in the maintenance log on their particular floor identifying the maintenance required and maintenance worker checks the maintenance log every morning and dates and signs when the work is completed.
The PSWs confirm that the completion time varies depending on the availability of supplies, parts and equipment.

During an interview and observation tour of the homes identified areas of disrepair the Administrator confirmed that the maintenance will be prioritized and addressed. [s. 15. (2) (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 the home, furnishings are maintained in a safe condition and in a good sate of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

Related to Log#031467-15:

Interview with resident #043 and his/her SDM on a specified date indicated that the air temperature in the room has been noted too hot or too cold. Interview with staff #136 indicated that the home's air temperatures are being monitored daily using the corridor temperatures on the home areas.
A review of the home's temperature log indicated that on the following dates the air temperature in the home was 20.5 degrees or 69 Fahrenheit less than the minimum requirement of 22 degrees:
June 1-69 degrees
June 19-69 degrees
July 20- 68 degrees
August 7, 2015- 69 degrees
August 10, 2015- 69 degrees
August 27, 2015-66 degrees
August 28, 2015- 69 degrees
Sept. 7, 2015 - 69 degrees
Sept. 14, 2015- 68 degrees
Sept. 16, 2015- 69 degrees
Sept. 21, 2015 -69 degrees
Sept. 23, 2015- 68 degrees
Sept. 25, 2015- 69 degrees

Discussions were held with the Administrator who indicated that the boiler system and two air exchange units on the roof were replaced in October, 2015, and that the air temperature is monitored and continues to be adjusted to maintain temperature of 22 degrees. She confirmed that the expectation is for air temperature in the home be maintained at a minimum of 22 degrees. [s. 21.] (607). [s. 21.]

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 home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring that staff participate in the implementation of the infection prevention and control program.

The home's policy, Practicing Hand Hygiene (#IC-02-01-07), states that the home participates in the provincial and national hand hygiene program, which includes "Just Clean Your Hands". The policy directs that hand hygiene is required, but not limited to, before and after contact with any resident their body substances or items contaminated by them (the resident), between different procedures on the same resident, and after touching any high touch surfaces such as keyboards, touch computer screens (e.g. eMAR). The policy indicates that "The Four Moments of Hand Hygiene", includes that hand hygiene will be performed before initial contact with resident or resident environment; before aseptic procedures; after body fluid exposure risk; and after resident/resident environment contact.

The following was observed (by the inspector):

- On a specified day, during, a lunch time, medication administration observation, Registered Practical Nurse (RPN #109) was observed preparing and administering medications (oral) to three residents without performing hand hygiene before or after resident and or resident environment contact; during this same observation RPN #109

was seen touching the medication cart, the electronic eMAR (electronic medication administration record) monitor and applying a bandage to one female resident's finger (all completed without hand hygiene performed before or after contact with the above).

Registered Nurse (RN #106) and RPN #109 indicated (to the inspector) that the home follows "Just Clean Your Hands – 4 Moments of Hand Hygiene" practices; both registered nursing staff indicated hand hygiene was to be performed before and after resident and or resident environment, which includes before and after medication administration.

Registered Practical Nurse #109 indicated (to the inspector) that she normally cleanses her hands before and after administering medications to residents, but must have forgotten.

The Director of Care indicated (to the inspector) it is an expectation that hand hygiene is performed consistently by all staff; DOC indicated that all staff have had annual education regarding infection control practices and such includes hand hygiene and the importance of the same. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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.

Related to Log#031467-15

During the course of this inspection the inspectors observed the following:
January 4, 5, 6, 7, 8, 11, 12, 13 and 14 on the second and third floor east/west corridor contained wheelchairs, transfer mechanical lifts, soiled linen carts and fans obstructing both sides of the corridor.
Interview with registered staff #147 confirmed the above identified equipment observed in the corridor and indicated that there are residents who ambulate along the corridor and that residents do not have access to the hand rails on either side of the corridor causing a safety risk.
The Administrator acknowledged that the home is an older home with limited storage. [s. 5.] (607) [s. 5.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Resident Abuse by Persons Other Than Staff (#OPER-02-02-04) states that Extendicare is committed to providing a safe and supportive environment in which all residents are ensured dignity and respect.

The policy directs that all persons in the home will:

- If abuse is witnessed, are to separate the resident from the alleged perpetrator; call for assistance if there is a risk to safety of any person. If the situation becomes unsafe at any time, all persons are to not hesitate but to call police;
- Stay at the scene to provide comfort and reassurance to the resident as needed;
- Immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or their designate (e.g. supervisor or department head); in addition, anyone who suspects or witnesses abuse that causes or may cause harm to a resident is required by the LTCHA, to immediately contact the Ministry of Health and Long Term Care (Director);
- Staff failure to report verbally the incident to the Administrator, Director of Care or their designate immediately could result in disciplinary action.

The policy directs that upon notification, the Administrator, Director of Care or designate will:
- Upon notification of suspected or witnessed abuse, assess the resident and confirm the resident is safe;
- If required, such as the case of physical (or sexual assault) have the resident assessed (for injuries);
- Provide emotional support to the resident; do no leave the resident alone;
- If circumstances are unsafe, contact the police or if a criminal offence has taken place (e.g. physical assault); otherwise confer with Regional Director as whether or not to contact the police;
- Initiate an internal investigation and complete a preliminary report before going off duty; all staff having knowledge of the incident is to remain on duty until they are excused by the person completing the preliminary report; document pertinent details of the investigation, actions taken during the investigation and actions taken as a result of the outcome of the investigation.

The policy further directs that the Administrator, Director of Care and or designate will take the following actions against the alleged perpetrator (e.g. family):
- Advise the person that there has been a report of suspected or witnessed resident abuse (Note: it is the discretion of the home to refrain from notifying the power of attorney or substitute decision maker that a case of suspected or witnessed abuse has been made against them; this discretion is permitted to protect the integrity of the investigation and the safety of the resident);
- Request that the person leaves the premises immediately;
- Advise the person that they will be contacted to discuss the issue. If physical (or sexual abuse) advise that the police have been contacted;

- If the abuse has been substantiated (e.g. by the family member), limit contact with the resident to supervised visitation as per the Supervised Visitation policy or if required, where appropriate, institute a visitation ban (Note: before a visitation ban is instituted, confer with Regional Director).

Related to Intake #011772-15, for Resident #045:

According to the clinical health record, resident #045 has a medical diagnosis which includes cognition impairment. Personal Support Workers, Registered Nursing Staff and the Director of Care indicated (to the inspector) that resident relied on staff for all activities of living.

The clinical health record for resident #045, was reviewed by the inspector, for a particular six month period; progress notes for this time period provide details of five incidents where Personal Support Workers (PSW) and Registered Nursing Staff overheard or witnessed resident #045's POA (Family #046) being verbally and or emotionally abusive towards resident, force feeding resident despite resident refusing intake or verbally indicating not wanting anymore food to eat, and one occasion a PSW heard resident's bed being shaken from the hallway; PSW indicated to registered nursing staff that he/she overheard Family #046 say to resident #045 "I'm going to shake the hell out of you so you wake up".

The licensee failed to comply with the home's policy "Resident Abuse by Persons Other Than Staff" as evidenced by the following:

- Alleged or witnessed family to resident abuse (verbal, emotional) of resident #045 by Family #046 is documented in the progress notes as having had occurred on five occassions during the particular six month period; there is no documented evidence to support that the Director (Ministry of Health and Long-Term Care) was immediately notified of the said incidents, despite Personal Support Workers, Registered Nursing Staff, members of the management team and the physician having had knowledge of an incident or incidents of the abuse;

- There is no documented evidence to support that Registered Practical Nurse, unit supervisor, for two of the incidents, notified the RN-Charge Nurse of the alleged or witnessed incidents of abuse of resident #045 by Family #046 as per the home's policy; nor is there documented evidence to support that the Director of Care, Administrator or designate was notified of the alleged or witnessed abuse or resident #045;

-Interviews with PSWs, RPNs, RN and ADOC they told the inspector that they had reported the information to the Director of Care.

-Of the five incidents of documented family to resident abuse, the Director of Care indicated she was only aware of one incident and had not been notified by registered nursing staff of the other incidents of abuse of Resident #045, despite the policy of the home indicating that the Administrator, Director of Care or designate will be immediately notified of abuse.

- There is no documented evidence to support that the Registered Nurse-Charge Nurse (specifically for three of the incidents)was notified immediately (or at all) by Personal Support Workers or Registered Practical Nurses of the family to resident abuse incidents;

- There is no documentation to support that the incidents of family to resident abuse was investigated and documented as per the home's policy (Resident Abuse by Persons Other than Staff); Director of Care indicated having no documentation other than the progress note entries that an incident or incidents occurred;

- The Director of Care indicated (to the inspector) that the police were not notified of the abuse incidents (for the specified six month period) despite two progress notes detailing staff or managers telling Family #046 that his actions were abusive and reportable to the police;

- There are no Critical Incident Reports submitted to the Director (Ministry of Health and Long-Term Care) for any of the documented incidents of abuse of resident #045, despite documentation of the incidents having been witnessed or alleged during the specified six month period, and despite RN-Charge Nurse (designate), Assistant Director of Care and the Director of Care having knowledge of the specific incidents.

- The policy directs that the Administrator, Director of Care or designate directs that the alleged perpetrator (includes family) will be requested to leave the premises immediately; there is no documentation to support that Family #046 had been asked to leave the home when abuse was alleged or witnessed.

The Administrator and Director of Care indicated (to the inspector) that all staff have been provided education and or re-training specific to the home's policies relating to zero tolerance of abuse and mandatory reporting; Administrator and Director of Care both

indicated it is an expectation that home policies are to be followed. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure written complaints received by the home that concern the care of a resident or the operation of the long-term care home were immediately forwarded to the Director

Related to Log#031467-15

Resident #043's SDM submitted a written letter of complaint to the home on two specified dates identifying multiple concerns related to provision of care by staff and the temperatures in the building.

The Director of Care confirmed that she received the letters of complaint and forwarded them to the Director. Review of the email provided by the DOC and the Ministry of Health Central Access and referral confirm that the home has not forwarded this written complaint to the Director to date of this inspection. [s. 22. (1)] (607) [s. 22. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director specifically,

Abuse of a resident by anyone that resulted in harm or risk of harm.

Related to Intake #011772-15, for Resident #045:

Resident #045 has a history which includes cognition impairment.

The clinical health record, for resident #045, was reviewed (by the inspector) for a specified six month period. Progress notes provide documentation of five incidents of alleged or witnessed verbal and emotional abuse of resident #045 by Family #046 (as indicated by Written Notification #1).

There is no documentation to support that Registered Practical Nurses #124 or #126 immediately reported the alleged or witnessed abuse of resident #045 to the Director. Registered Practical Nurse #124 indicated (to the inspector) that the abuse incident, which occurred on on specific date was reported to the Director of Care, on the date to which it was said to have occurred.

Registered Nurse #125, who is the evening charge nurse, indicated (to the inspector) she reported that an incident occurred to the Assistant Director of Care, who she (RN #125) believes was in the home at the time of the alleged abuse incident. Registered Nurse #125 indicated that two incidents were not reported to the Director by herself. Registered Nurse #125 indicated (to the inspector) being aware that incidents of abuse are to be reported to the Ministry of Health and Long-Term Care, and further indicated awareness of the home's zero tolerance of abuse policies. Registered Nurse #125 indicated she did not report the incidents as she felt that the resident was not in any danger.

Assistant Director of Care indicated (to the inspector) that the incident which was said to have occurred on a particular date was reported to her by Registered Nurse #125; Assistant Director of Care indicated (to the inspector) that she did not report the incident to the Director (MOHLTC). Assistant Director of Care indicated awareness of other incidents of alleged, suspected or witnessed abuse of resident #045 by Family #046 but indicated the direction by Acting Administrator was to deal with the incidents in home.

The Director of Care indicated (to the inspector) being aware of the most recent incident of abuse of resident #045 by Family #046. Director of Care indicated that the administrative team met with Family #046 on the next day to discuss the incident. Director of Care indicated that she and other managers were told by the Acting Administrator to not report, the most recent incident to the Director (MOHLTC) but to keep incident in house. Director of Care indicated in her initial interview (with the inspector) that registered nursing staff or others had not notified her of any of the other alleged, suspected or witnessed abuse incidents which were documented to have occurred.

Registered Practical Nurse #124, Registered Nurse #125, Director of Care and the Administrator all indicated that yelling, swearing, force feeding and shaking a resident's bed would be considered abusive.

During a second interview, the Director of Care indicated (to the inspector) that she was aware of the concerns of several nursing staff specific to the alleged or witnessed abuse of resident #045, but that she and other managers were told by the Acting Administrator to deal with the incidents in home. Director of Care indicated that in hindsight the incidents should have been reported as per the home's policy (Resident Abuse by Persons Other Than Staff).

The Director of Care indicated (to the inspector) that the alleged, suspected or witnessed abuse incidents of resident #045 by Family #046 were not immediately reported to the Director. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 32 where by resident #37 did not receive individualized care with shaving on a daily basis.

Resident #37's plan of care indicates that resident #37 requires assistance of one staff for personal hygiene and grooming. The plan includes staff are to provide extensive assistance for resident to shave.

The plan of care also indicates staff are to use an electric razor.

On a specified date during an interview with resident #37 and the resident's substitute decision maker (SDM) both indicated that resident #37 is not being shaved on a daily basis. They indicated that resident #37 is shaved twice a week by staff on bath days and that the SDM shaves the resident in the afternoon the remaining days when he/she visits with the resident.

On a particlar date during an interview with PSW #108 he/she confirms that he/she does not always have time to provide the extensive assistance with shaving required on a daily basis and confirms that resident #37 is guaranteed to be shaved on bath days and that the resident's SDM often assists by shaving the resident when visiting.

On the same day the Administrator confirmed during an interview that the expectation is that if a resident has not been provide individualized care on the day shift the evening staff would complete the care and shave the resident. [s. 32.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Log#031467-15

An interview with resident #043 and his/her SDM on January 11, 2016 and further interview with the resident January 13, 2016 revealed that on a particular date, the resident had missed a scheduled bath because the home was short staff. A review of the plan of care revealed that the resident is scheduled to have baths on Thursdays and Sundays between 1500-1100 hours, and requires extensive assistance with all aspects of bathing and two staff are to assist with this process. The resident states that "he/she was going out that evening and waited for a bath and no one came to offer him/her a bath. After waiting until 5:00 p.m., he/she later left for an appointment and returned to the home about 8:30 p.m. He/she then waited to be offered a bath and no one came to offer him/her a bath, at which time resident #043 got dressed and went to bed." A review of the clinical record for the resident revealed that on the particular date staff #148 documented that bath was not given to the resident on the above scheduled bath day as the resident was not available . Interview with the S #148 indicated that the resident did miss his/her bath on this date because he/she went out and a bath was offered upon return, but the resident refused. A review of the clinical records indicated that a bath was not given to the resident until the next schedule bath date three days later. [s. 33. (1)] (607). [s. 33. (1)]

WN #13: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 76 (4), by not ensuring that all staff have received retraining annually relating to the following:

• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24

Administrator indicated (to the inspector) that home switched from face-to face inservice education mid-2015 to "iTacit" (the home's electronic education program), indicating that the switch to iTacit (from face to face) caused issues monitoring that staff were completing the required mandatory education (which included, zero tolerance of abuse and mandatory reporting).

The Administrator indicated (to the inspector) and provided statistics showing that only 93.7% of staff completed the above mandatory education in 2015. Administrator indicated that there was no reason for all staff not to have had completed the required retraining.

The Administrator indicated it is an expectation that all staff complete the annual re-training and will be an area of improvement in 2016. [s. 76. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are implemented for addressing incidents of lingering offensive odours.

The home's policy, Dealing with Persistent Odours (#HL-05-03-08) speaks to the home will investigate and correct lingering odours as soon as possible. The policy directs that all staff will immediately report any lingering odours to the Support Services Manager. The policy directs that the Support Services Manager (or designate) will identify the source of the odour using the "Odour Control Investigation Tool" as a guide; if unable to identify source of the odour, review the area with odour issues at various times of the day to establish if the odour is ongoing; look at interdisciplinary team process, procedure and systems for possible cause; investigate the area again in one to two weeks if needed to see if there is a change, if the odour persists, repeat the investigation.

The following was observed (by the inspector):

- Unit Two, resident #044's room – a foul odour, which resembled the smell of urine, was identified upon entrance to the residents room (shared basic room); the odour became more intense and prevasive as you entered the washroom. The lingering and offensive malodour was noted on January 05 , January 06, January 07 and January 08, 2016 .

- Unit Two, resident #20's room – a foul lingering odour, which resembled the smell of urine, could be immediately identified upon entering the washroom in this resident room (this is a shared washroom and adjoins to the next resident room). The lingering and offensive malodour was noted on four consecutive days at different times of the day.

A Personal Support Worker (PSW #133) indicated (to the inspector) that resident #020, the only resident who uses the washroom "toilets his/herself and indicated resident #020 is at times incontinent of urine which may be contributing to the odour. PSW indicated that there is often a strong smell of urine in the washroom.

Personal Support Worker #143 indicated (to the inspector) that the odour in the room of resident #044's is a result of the resident being incontinent on the floors in the washroom and the floors not being immediately cleaned up, causing it to seep under the base of the toilet and flooring.

Housekeeping Aide (HSK Aide #110), who is the full-time housekeeping staff for unit two, indicated (to the inspector) being aware of the home's policy "Dealing with Persistent Odours" but indicated no awareness of the lingering malodour present in the room of resident #020 and resident #44. HSK Aide #110 indicated that there are currently no additional cleaning measures in place for the rooms indicated above.

Support Services Manager indicated (to the inspector) not being aware of any odour concerns on Unit Two (specifically in rooms of resident #02 and resident #044), but later on in the interview indicated being aware that the resident #044 has very strong urine ; and that resident #020 often is incontinent on the floor in the washroom. Support Services Manager indicated that there are currently no measures in place in either resident rooms (#236 and #241) to manage lingering offensive odours.

Administrator indicated (to the inspector) that it is an expectation that lingering offensive odours are to be addressed and managed. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 98, by not ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incidents of abuse of a resident that the licensee suspects may constitute a criminal offense.

The clinical health record, for resident #045, was reviewed (by the inspector) for a specified six month period; progress notes provide documentation of five incidents of alleged or witnessed (verbal and emotional)abuse towards resident #045 by Family #046.

Progress notes reviewed provide documentation in which the Family #046 was told by staff (personal support workers, registered nursing staff and members of the management team) that his/her actions towards resident #045 were "abusive" and two progress notes specifically (the last month) speak to staff or managers telling Family #046 that police could be called due to his/her actions.

Director Care and Administrator indicated (to the inspector) that yelling, swearing, force feeding of a resident or shaking a resident's bed with resident in it would be considered abusive in nature.

During a second interview, the Director of Care indicated (to the inspector) that she was aware of the concerns of several nursing staff (personal support workers and registered nursing staff) specific to the alleged or witnessed abuse of resident #045, but that she and other managers were told by the Acting Administrator not to call the police and to handle the incidents in house. Director of Care indicated that in hindsight the incidents should have been reported as per the home's policy (Resident Abuse by Persons Other Than Staff).

Director of Care indicated (to the inspector) that none of the alleged or witnessed abuse incidents (family to resident) documented as having had occurred during the specified six month period were reported to the police. [s. 98.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101 (1)(2) where Resident #043's SDM did not receive a written response acknowledging receipt of the complaint including the date by which the complainant can reasonably expect a resolution within 10 business days.

Related to Log #031467-15:

Resident #043's SDM submitted a written letter of complaint to the home on two separate occasions identifying multiple concerns related to provision of care.

During an interview with the Director of Care and review of complaints records she confirmed that a written response acknowledging that the complaints had been received or a date the complainant could expect a resolution was not sent within 10 business days.[s. 101. (1) 2.] (607) [s. 101. (1) 2.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 101 (1)(3)were by Resident #043's SDM did not receive a written response indicating what had been done to resolve the complaint or that the licensee believed the complaint to be unfounded and the reasons for this believe.

Related to Intake Related to Log#031467-15:

Resident #043's SDM submitted a written letter of complaint to the home on a specified date identifying multiple concerns related to provision of care and also the concerns that were not responded to in the written letter of response received from the home for another complaint that was submitted at an earlier date.

During an interview with the Director of Care and review of complaints records confirm that a response was not provided to resident #043's SDM that indicated what had been done to resolve the complaint or if the complaint had been believed to be unfounded and the reasons for this believe. [s.101. (1) 3.] (607) [s. 101. (1) 3.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 129 (1) (a) ii, by not ensuring drugs are stored in an area or a medication cart, that is secure and locked.

The following was observed (by the inspector):

- On a specified date, at approximately 10:47 hours to 11:09 hours, the medication cart (#CO2865) on unit two was observed to be unlocked and accessible to residents and others; the medication cart was in the hall by the nursing station which is open to the lounge. During this observation there were approximately fifteen residents sitting within close proximity (in the lounge) of the medication cart; no staff were present during the same observation.

Charge Nurse-Registered Nurse (RN #106) indicated that Registered Practical Nurse (RPN #109) had gone on her break and must have forgotten to lock the medication cart. At 11:09 hours, RN #106 locked the medication cart. Registered Nurse #106 indicated that the medication cart is to be locked whenever registered nursing staff are not present.

Registered Practical Nurse #109 returned from break at approximately 11:20 hours and indicated (to the inspector) that she must have forgotten to lock the medication cart. RPN #109 indicated that she was aware that that medication cart was to be locked when not in attendance.

Director of Care indicated (to the inspector) that the medication cart is to be locked at all times when registered nursing staff are not in attendance. [s. 129. (1) (a)]

Issued on this 19th day of February, 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), KELLY BURNS (554), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2016_270531_0001
Log No. / Registre no:	031622-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 18, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE OSHAWA 82 PARK ROAD NORTH, OSHAWA, ON, L1J-4L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBORAH WOODS

To EXTENDICARE (CANADA) 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 will prepare, implement and submit a corrective action plan to ensure that residents are protected from verbal, emotional and physical abuse by anyone.

All staff are to complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners specific to, Zero Tolerance of Abuse. The education should include, but not limited to:
- Definitions of abuse as defined by the regulation(s), with a heightened Emphasis of the definition of verbal, emotional and physical abuse;
- An explanation of 'duty to report' as it relates to LTCHA, 2007, s. 24 and the requirements relating to making mandatory reports;
- The use of the MOHLTC Abuse Decision Tree Algorithms (as a guide);
- the relationship between power imbalances between care providers (e.g. family) and residents and the potential for abuse by those in positions of trust, power and responsibility for care, and situations that may lead to abuse and how to avoid such situations and how or when to intervene when required;
- Person who are to be notified in incidences of alleged, suspected or witnessed incidents of abuse;
- Taking appropriate actions to safe-guard residents in incidence(s) of alleged, suspected or witnessed abuse;
- A review of the home's specific policies relating to Resident Abuse by Persons Other Than Staff, Supervised Visitation and any other home related policy specific to Resident Abuse (reporting, investigating and reporting), Mandatory Reporting, Resident Bill of Rights, and Mandatory Reporting.

The licensee is to ensure there is a process in place to monitor the effectiveness of the education and a process to ensure sustained compliance relating to reporting requirements specific to Section 24; notification of required individuals in incidence of alleged, suspected or witnessed abuse, specifically verbal, emotional and physical abuse; and the need to ensure appropriate interventions are taken to safe-guard residents from abuse by anyone.

The licensee will provide a written plan on or before March _10__, 2016; the plan must be submitted in writing and forwarded to the Attention of: LTC Homes Inspector, Nursing Kelly Burns, at the following fax # _613-569-9670_____

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 19 (1), by not ensuring

Resident #045 was protected from abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening,insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Related to Intake #011772-15, for Resident #045:

Resident #045 has a cognitive impairment, and relies on staff for all activities of daily living.

Progress notes, for resident #045, were reviewed for a period of approximately six months. The progress notes provide details of five separate incidents in which Personal Support Workers and Registered Nursing Staff witnessed or suspected abuse of resident #045 by Family #046. Progress notes detail Family #046 yelling, swearing, forcefully shaking Resident #045's bed (with him/her in it) and force feeding the resident. The reviewed progress notes, provide details of resident #045 telling his/her family to "stop feeding him/her", indicating "I've had enough"; the progress notes indicate family continued to feed resident despite pleas to stop. Progress notes indicated that Family #046 was told, by Personal Support Workers and Registered Nursing Staff, that his/her actions were abusive and that the police could be called, in which Family #046 indicated, if I don't make resident #045 eat, he/she is going to starve.

Progress notes reviewed, for a specific date, failed to provide documentation that Registered Practical Nurse #126 reported a witnessed incident of resident #045 to the RN-Charge Nurse.

During interviews, with the inspector, RN-Charge Nurse #125 indicated that the

Assistant Director of Care and the Social Worker were told of the incidents of suspected and or witnessed abuse of resident #045 by Family #046. RN-Charge Nurse #125 indicted that the incidents of abuse of resident #045 were not reported to the Director (MOHLTC) or to the police.

The Assistant Director of Care (ADOC) indicated being aware of the family to resident abuse incident, which occurred on a specific date, and which was reported to him/her by RN #125. ADOC indicated reporting the incident to the Director of Care. Assistant Director of Care indicated that yelling, swearing and force feeding of a resident could be seen as abusive, but it was believed by the Director of Care and the Social Worker that Family #046 was merely not coping with the change in resident #045's condition. ADOC indicated not speaking with the resident about the incident. ADOC indicated that the incident, which was reported to him/her was not reported to the Director (MOHLTC).

On an identified date, Family #046 was heard by PSW #123 yelling and swearing at resident #045. PSW entered resident's room and found Family #046 forcefully shaking resident's bed (with resident in it) and heard yelling "I'm going to shake the hell out of you so you wake you". Family #046 was told by PSW #123 his/her actions were abusive and that if he/she didn't stop the police would be called. PSW #123 reported the witnessed abuse to RPN #124.

Registered Practical Nurse #124 indicated that he/she did not go down to resident #045's room to assess the resident, as PSW #123 did not indicate resident was in any danger. RPN #124 indicated he/she did not speak with Family #046 as to the witnessed incident.
Registered Practical Nurse #124 indicated he/she did not report the witnessed abuse incident to the Director (MOHLTC) or to the police, as he/she had reported the incident, on the date to which it occurred, to the Director of Care.

The Director of Care acknowledged awareness of the fifth incident involving Family #046 and Resident #045, but indicated not being made aware of the incident until the day after the incident occurred.

Director of Care indicated that a meeting, involving herself, the Acting Administrator, Social Worker and the Dietitian was held with Family #046 to address the fifth incident and at that time Family #046 was told that his/her interaction with resident #045 was abusive. Director of Care indicated that the Acting Administrator and the Social Worker reminded Family #046 of the home's

zero tolerance of abuse policy and the home's requirement to report abuse.

Director of Care indicated that incident (fifth incident) was not reported to the Director (Ministry of Health and Long-Term Care) as the decision by the administrative team was to handle the incident in house. Director of Care indicated being told by the Acting Administrator "not to report the abuse incident to the Ministry of Health and Long-Term Care or the police".

The Director of Care indicated that during meeting with Family #046, he/she (family #046) indicated to the administrative team, that "he/she and resident #045 always talked to each other that way, when resident was well". The Director of Care confirmed that Resident #045 was cognitively impaired and was not able to defend self from others. Director of Care indicated "Family #046 was not coping with Resident #045's overall decline and such may have been affecting his/her behaviour".

The Director of Care indicated that she and other members of the nursing management team (Assistant Director of Care, and Clinical Coordinator) review home's progress notes on a daily basis; Director of Care indicated no awareness of the other incidents of alleged or witnessed abuse of resident #045 by Family #046, which were said to have occurred during a six month period.

Director Care and Administrator indicated that yelling, swearing, force feeding of a resident or shaking a resident's bed with resident in it would be considered abusive in nature.

During a second interview, the Director of Care indicated (to the inspector) that she was aware of the concerns of several nursing staff (personal support workers and registered nursing staff) specific to the alleged or witnessed abuse of resident #045, but that she and other managers were told by the Acting Administrator not to call the police and to handle the incidents in house. Director of Care indicated that in hindsight the incidents should have been reported as per the home's policy (Resident Abuse by Persons Other Than Staff).

The Acting Administrator was unavailable for an interview as he/she no longer employed by this home.

The Administrator indicated that it is an expectation that alleged, suspected or witnessed abuse it to be immediately reported to the Administrator, Director of

Care and or designate (management or charge nurse). Administrator further indicated that abuse is to be immediately reported as per the legislative requirements.

Administrator indicated that all staff are expected to follow the home's policy and procedures as it relates to "zero tolerance of abuse".

The licensee further failed to comply with the following:

- Under LTCHA, 2007, s. 24 (1) 2 - A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically, abuse of a resident by anyone that resulted in harm or a risk of harm to the resident. (as indicated by Written Notification #10)

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

- Under LTCHA, 2007, s 6 (1) – Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specific to verbal and emotional abuse of resident #045. (as indicated by Written Notification #3)

- Under LTCHA, s. 76 (4) - Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. Under subsection (2) all staff to receive annual training specific, to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports. (as indicated by Written Notification #13)

- Under O. Reg. 79/10, s. 98 - Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the

licensee suspects may constitute a criminal offense. (as indicated by Written Notification#15)

Scope and severity Summary:
Over a seven month period, there were five documented incidents of alleged, witnessed and or suspected abuse of resident #045, by Family #046 which caused the resident significant emotional distress where the resident was overheard pleading with the family member to stop.

(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_328571_0026, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall submit a detailed written plan by March 10 , 2016 that includes who will verify illumination levels in each space identified below, what will be done (fixtures added, replaced, modified, retrofitted) and by whom, and the time lines for completion indicating:
1. Which resident rooms will have existing ceiling light fixtures replaced with one or more light fixtures that provide a minimum of 215.28 lux in areas at the foot of each bed, between each bed, at the wardrobe and path leading to the bed and under each sink.
2. Which resident rooms will require either the addition of a ceiling light fixture or the replacement of one or more over bed lights with a light fixture that can illuminate the areas of the room as identified in #1 above.
3. How the chandelier lights in the main dining room will be retrofitted to produce a lux of 215.28 directly under the light, over the tables and around the tables, and in front of the servery in the dining room on the 2nd and 3rd floors. How the illumination will be increased in the small corridor leading to the 1st floor dining room.
5. How many lights and in which corridors will be replaced with a new light fixtures and/or lights or specifically which corridors will receive additional lighting fixtures in order to meet the minimum level of 215.28 lux down the centre of every corridor.
6. Which lounge, common spaces, tub, and shower rooms will have their light fixtures modified or
replaced to ensure that the rooms are illuminated in areas where residents sit or complete an activity (reading, puzzles, crafts, knitting etc) to meet the minimum requirement of 215.28 lux.
7. Where retrofitting is not a possibility, what other illumination solutions will be used to meet the minimum requirement of 215.28 lux.
9. How electrical compliance with ESA requirements will be maintained throughout the project.

The actions identified above are to be implemented by July 30, 2016. The written plan is to be submitted to Lynda Brown by email OttawaSAO.MOH@ontario.ca or by fax to 613-569-9670 by March 10, 2016.

Grounds / Motifs :

1. Related to log # 008736-15:
The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "In all other areas of the home". A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in various locations in the home. While using this light meter, the operating error of < 10% was used to determine adequate lighting levels. The meter was held a standard 30 inches above and parallel to the floor. Lighting conditions were clear and sunny day outdoors at the time of the inspection and in order to prevent natural light from affecting indoor measurements all efforts were made to control the natural light. Window coverings were drawn in resident bedrooms, lounges and dining rooms tested, lights were turned on 5 minutes prior to measuring and doors were closed where possible (i.e. corridors). Areas that could not be tested due to natural light infiltration included the area in TV lounges directly in front of windows due to no window coverings available and end of corridors.

For this follow-up inspection, several resident bedrooms, resident washrooms, tub and shower rooms, 1st, 2nd and 3rd floor dining rooms, all corridors/lounges on each floor, were measured to determine current lighting levels. The areas below were found to be non-compliant with the lighting table:

Corridors/dining rooms/lounges:

January, 11, 2016
First floor:
-there are two long corridors and one short corridor (leading to front offices). The two long corridors had ceiling mounted fluorescent tube lights (troffer lights) as well as a ceiling mounted, semi-flush large circular fixture with opaque lens with compact fluorescent lights down the centre ceiling of the hallway spaced approx. 6 feet apart. All doors were closed and lights were turned on. Several of the ceiling mounted circular lights had a large amount of dead flies noted inside the fixtures. The ends of the long corridors and in front of the nursing station were affected by the natural light and therefore, not measured due to large windows where no curtains were available to close off natural light.
-the small TV lounge was measured with a reading of 110 lux with all lights turned on.
-the corridor starting at room 109: outside of room 109 and directly under the ceiling mounted, semi flushed large circular fixtures the light had a reading of 160 lux. Between the circular fixture lights the reading was 100 lux.Outside of room 106 & 107,directly under the dome light, had a reading of 62 lux.
-the small corridor entering the dining room had 2 chandelier lights which were

turned on. The door entering the smaller dining room was also closed. The area in front of the public washroom in this same small corridor was 105 lux. The main dining room lighting was greater than 215.28 lux.
-the activity lounge lighting was also greater than 215.28 lux.

January 12, 2016:
2nd floor:
-there are two long corridors separated by the TV lounge, nursing station and elevator connecting the two, as well as one short corridor (leading to the dining room). The long corridors have approximately 1-2 feet diameter ceiling mounted, semi-flushed circular fixture with opaque lens with compact fluorescent lights down the centre spaced approximately 8 feet apart and the short corridor the ceiling mounted semi-flushed circular lights are spaced approximately 4-6 feet apart. All doors were closed and lights turned on. It was an overcast day.
-the corridor starting from room 240: from room 240 to 247 had light readings of 180 -190 lux directly under the lights and light reading ranging from 60-120 lux in between the ceiling mounted circular lights; from room 249-258 had light readings greater than 215 lux but this was affected by the natural light at end of the hallway.
-the TV lounge had 8 large semi-flush circular fixtures with an opaque lens spaced approximately 4-6 feet apart that were turned on and two large windows at end of TV lounge that had no curtains to remove all natural light. The area directly in front of the elevator had a reading of 115 lux. The area in front of the nursing station had a reading of approximately 160 lux. Approximately 10 feet from the window (close to the large post in the centre of the TV lounge) had a light reading of 180 lux (with natural lighting affecting the reading from the large windows).
-the corridor from rooms 201 to 219 had 10 large ceiling mounted circular lights spaced approximately 8 feet apart. Outside of room 201 had a reading of 115-120 lux. between room 204 & 205 had a reading of 130-135 lux, between room 206 & 207 had a reading of 55 lux directly under the circular light, between room 207 & 209 directly under the circular fixture light had a reading of approximately 90 lux, the small corridor in front of the bath/shower room (with light turned on) had a reading of 85 lux, the corridor from room 211-217 had reading of 140-160 lux.
-the short corridor from rooms 231 to 236 had ceiling mounted semi-flush circular fixtures with an opaque lens lights spaced approximately 4-6 feet apart. Outside of room 232 had reading of 120-130 lux, and outside of room 236 had reading of 170-175 lux.

3rd floor:
-the long corridor from rooms 340 to 358 had 9 large ceiling mounted, semi-flush circular fixtures with opaque lens with compact fluorescent lights down centre of ceiling spaced approximately 8-10 feet apart. This corridor had a large window at the end of the hall that did not have a curtain to remove natural light. The light reading between the lights ranged from approximately 60-180 lux; outside of room 349 and directly under the large circular fixture light had a reading of 140 lux.
-the TV lounge had 8 large ceiling mounted, semi-flush large circular fixture with opaque lens with compact fluorescent lights spaced approximately 8 feet apart and had 2 large windows with no curtains available to remove all natural light. One of the ceiling mounted semi-flush circular lights was burned out (closer to the nursing station) and had a reading of 80 to 110 lux. The areas closest to the elevator had a reading of 130 lux and in the middle of the TV lounge had a reading of 170 lux.
-the dining room had 11 chandelier lights and 5 scone lights. All windows had curtains closed to remove all natural light. Majority of the dining room had readings greater than 215 lux except between tables 8, 9 & 11 where the reading was only 170 lux and in front of the servery where the reading was 115 lux.
-the short corridor (outside of dining room) with rooms 334 to 350 had 4 large ceiling mounted semi-flush circular fixtures with opaque lens with compact fluorescent lens, the lights spaced approximately 8 feet apart. Outside of room 334 had a reading of 55 lux, between rooms 331 & 332 had a reading of 100 lux, in front of the MDS work station (placed in the same corridor) and directly under the light had a reading of 140 lux.
-the long corridor starting at room 301 had large ceiling mounted semi-flush circular fixtures with an opaque lens with fluorescent lights spaced approximately 10 feet apart. There was a large window at the end of this corridor and no curtain to remove all natural light. All lights were turned on and resident's doors closed. Between room 304 & 305 had a reading of 135 lux,
-the tub room had a large fluorescent light fixture directly above the tub. Between the sink and toilet had a reading of 50-80 lux but directly under the tub had a reading greater than 215 lux.

Resident rooms:
-most of the resident rooms in this home are semi private with two beds. There is one private room at the end of each long corridor on each floor and a 4 bed

basic room, just before the dining rooms on the 2nd and 3rd floors only. All of the resident rooms have a wall mounted compact fluorescent over-bed lights and one ceiling mounted small circular light fixture with an opaque lens over the sink area. The bathrooms had one large ballast fluorescent light and all the bathrooms indicated light readings of greater than 215 lux.
-room 255 was a semi private with two beds with 2 compact fluorescent over bed lights and one small circular fluorescent light over the sink area. All lights were turned on, with door and windows closed. In front of bed 1 (closest to the door) had light reading of 95-120 lux from door to beside the bed, greater than 215 lux at head of the bed directly under over bed lights, 95 lux directly under small round light at sink, 125 lux between bed 1 & 2, 75 lux standing directly in front the closet of bed 2 and end of bed 2.
-room 253 was a semi private with two beds and had all available lights turned on for greater than 10 minutes, with all door and window coverings closed. Bed 1& bed 2 had light readings of greater than 215 lux directly under the over bed light and at the head of the beds, bed 1 had a reading of 115 lux at the bedside, 85-90 lux in front of the sink and directly under the small circular light fixture, reading of 95-100 lux between bed 1 & 2, and 65-70 lux and the end of bed 2 and in front of the closet.
-room 251 was a semi private with two beds and all available lights turned on for greater than 10 minutes, with all door and window coverings closed. Both bed 1 & 2 had light readings of greater than 215 lux directly under the over bed lighting and at the head of the beds. Bed 2 had reading of 55-60 lux at the end of the bed and in front of the closet, 135-140 lux between bed 1 & 2, 75-80 lux under the sink, and 90-95 lux at entrance of room in front of bed 1.
-room 218 private room had one over bed light and a small circular light fixture over the sink. The door and curtains were closed and all lights turned on. The entrance of the room and in front of bathroom had a reading of 30 lux, 95 lux at the bedside, 75-80 lux in front of the sink and directly under the light fixture and in front of the closet, the area directly over the bed had a reading of greater than 215 lux.
-room 247 was a semi private room with two beds, an over bed light above each bed and a small circular light above the sink, the light reading was 50-60 lux at the entrance of the room and the bedside of bed 1, 155 lux directly under the sink and small light fixture, 35 lux in front of the closet and end of bed for bed 2, and 50 lux between bed 1 & 2. The lighting was adequate at the head of each bed under the over bed lights.
-room 355 was a semi private room with compact fluorescent lights in the over-bed lights and one small circular light above the sink area. All lights were turned

on and curtains and door was closed. The entrance of the room and in front of the bathroom had a reading of 60 lux, the reading between bed 1 & 2 was 185 lux, directly under the sink was 90 lux, at end of bed 2 and in front of the closet was 80 lux

Discussions were held with the Administrator on January 11, 2016 during the inspection regarding the status of the lighting upgrade plan after a tour of the home was completed. The full-time maintenance manager was unavailable to be interviewed. Interview of Administrator indicated the home received a quote in April 2015 by the company Neolumens (provided by corporate) to complete the work. The Administrator indicated she was on leave from the home from April to October, 2015 and none of the work had been completed. The Administrator indicated that a second quote was received in December 2015 by the same company to complete the work. The Administrator indicated the second quote still required approval by corporate so to date, "none of the lighting upgrades have been completed ".

The minimum required amount of 215.28 lux was not achieved in all areas of the home, as specifically identified above. This continuing pattern of non-compliance requires that the compliance order be reissued. Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents.Insufficient lighting may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents, including to conduct assessments and to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutrition intake and overall quality of life. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

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