Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2017	2017_644507_0008	013335-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Bloomington Cove Care Community
13621 Ninth Line Stouffville ON L4A 7X3

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

STELLA NG (507), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4 – 7, 10 – 14, 17 – 21, and 24 – 27, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
#030970-16 and # 032243-16 related to alleged staff to resident abuse,
#019892-16 related to responsive behaviours,

#007116-15 related to injuries with unknown cause, and #028118-15 and #032394-15 related to falls prevention.

The following complaints were inspected concurrently with the RQI: #014851-16 related to menu planning, pest control and alleged staff to resident abuse, #015614-16 related to maintenance, #024808-16 related to Resident's Bills of Right, #030468-16 related to alleged staff to resident abuse, #001429-17 related to infection prevention and control program, #003362-17 related to nutrition and hydration program, nursing and personal support services, continence care and bowel management, #011711-17 related to missing laundry and responsive behaviour management, and #014913-17 related to improper transfer, infection prevention and control program, continence care and bowel management and responsive behaviour.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspectors(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Scheduling Coordinator (SC), Recreational Therapist (RT), Physiotherapist (PT), Director of Environmental Services (DES), Handyman, Laundry Aide (LA), Housekeeping Aide (HKA), Registered Dietitian (RD), Director of Dietary Services (DDS), Dietary Aides (DA), private care giver, residents, Presidents of Residents' Council and Family Council, Substitute Decision Makers (SDMs) and family members of residents.

The inspectors conducted tour of the home, observations of staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, Residents' Council and Family Council meeting minutes, staffing schedules, employee files and relevant policies and procedures.

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
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **11 WN(s)**
- **2 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 :

1. The licensee has failed to ensure that resident #003 is protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to an incident that resulted in harm to resident #003.

Review of the above mentioned identified CIS revealed that on the identified date, resident #003 complained of pain to staff #116. Upon assessment, staff #116 noted resident #003 had altered skin integrity. During assessment, resident #003 reported to staff #116 that someone had pulled him/her when he/she was getting up on an identified date. Resident #003 was sent to the hospital for treatment.

During stage one of the Resident Quality Inspection (RQI), prevention of abuse and neglect was triggered for #003 as the resident's substitute decision maker (SDM) relayed the above mentioned incident to the inspector.

Review of resident #003's quarterly Resident Assessment Instrument –Minimum Data Set (RAI-MDS) assessment three weeks prior to the above mentioned incident, revealed that resident #003 had responsive behaviour in the last four to six days, but less than daily, and the behaviour was easily altered.

Review of resident #003's plan of care four days prior to the above mentioned incident, included a focus on the responsive behaviour. The goal for this focus was to reduce incidents of responsive behaviour and to ensure safety for resident and staff. Interventions included allowing resident #003 time to respond to directions, leaving the resident and re-approaching in five to ten minutes.

In an interview, resident #003 stated that a staff member pulled and twisted him/her causing an injury.

In an interview, resident #003's SDM stated that resident #003 told the family that on the above identified date, when he/she was resting, staff #117 asked the resident to get up for meal. Resident #003 told staff #117 that he/she would get up slowly and the staff left. When staff #117 returned, resident #003 was slowly getting up and staff #117 rushed resident #003 and pulled him/her up. Resident #003's SDM further stated the resident's recall of the incident remained consistent on the day of the incident and the day after.

In an interview, staff #117 stated that abuse is when you force the resident to do something they do not want to do. Staff #117 further stated that on the above identified

date, he/she called resident #003 for meal when the resident was resting, and staff #117 re-approached the resident three times. On the third approach, he/she forced resident #003 to get up. Staff #117 stated that at this time, resident #003 was exhibiting responsive behaviour, and not wanting to get up.

In an interview, staff #133 provided an example of abuse as trying to force someone to get out of bed when they don't want to. Staff #133 stated that resident #003 only exhibits responsive behaviour if you force him/her to do something he/she does not want to do.

In an interview, staff #134 stated that abuse can be any kind of unwanted physical touch and provided an example of not trying to force a resident to another area if they do not want to go.

In an interview, staff #120 defined abuse as putting a resident at physical risk, including improper or incompetent care that results in harm to the resident. Staff #120 acknowledged that forcing resident #003 to get up was an improper intervention as it could hurt resident #003.

B) Another identified CIS was submitted to the MOHLTC on an identified date, related to an allegation of staff to resident abuse resulting in injury to resident #004. The MOHLTC also received a complaint on the same day from resident #004's SDM of staff allegedly abusing the resident.

Review of the above mentioned CIS revealed that on an identified date, staff #107 observed resident #004 had altered skin integrity. Resident #004 told his/her family staff #136 had abused him/her.

Review of the above mentioned complaint revealed that resident #004's SDM stated resident #004 told the family that on the above mentioned identified date, he/she was being cared for by two staff, and was abused by one of them. Resident #004's SDM further stated that when resident #004 started to cry, the staff used a towel to cover the resident's mouth so that he/she would not make any noise.

In an interview, resident #004's SDM stated that on the above mentioned identified date, resident #004 had exhibited responsive behaviour and when the family visited, the resident had altered skin integrity and the resident was crying, pointing fingers at staff #115 and #136 and stated "he/she abuse me, he/she abuse me".

Review of a social and wellbeing assessment note in the progress notes, dated two months prior to the incident, revealed that resident #004 becomes unhappy if he/she is forced to do something, held tightly, or gets hurt.

Review of resident #004's full MDS admission assessment dated two weeks prior to the incident, revealed that resident #004 was assessed to have responsive behaviour symptom which was not being easily altered.

Review of resident #004's plan of care effective on the date of the incident, revealed a focus on responsive behaviour. The goal for this focus was to ensure safety for resident (s) and staff. The interventions related to this focus included staff to remain cognizant of not invading resident's personal space and to leave resident #004 alone if he/she is showing signs of being upset, and if safe to, re-approach at a later time.

Review of the progress notes on the same date, revealed that staff #136 reported to staff #157 that resident #004 was exhibiting responsive behaviour. Staff #157 instructed staff #136 to don protective gear on him/herself and the resident; however, resident #004 kept removing the protective gear. Further review of the progress notes revealed that on the same day, staff #107 reported the altered skin integrity of resident #004. Resident #004 told his/her family that he/she had been abused by a staff. On assessment, resident #004 had altered skin integrity.

Review of the home's investigation notes revealed the following:
- on an identified date, staff #136 stated that he/she and staff #115 wore protective gear and put one on resident #004 while providing care to resident #004 as instructed on the previous day by the management. Staff #115 was holding resident #004's hands as resident #004 was exhibiting responsive behaviours while the two staff continued to provide care. Staff #136 stated "I can't keep re-approaching, I don't have time. I think this resident thinks I'm the devil."
- two days later, staff #115 and #136 were provided letters of termination by the home as they had been determined to have engaged in the act of resident abuse.

In an interview, staff #115 stated that resident #004 was exhibiting responsive behaviour and the interventions at the time were to wear protective gear, and put one on the resident, as per the instructions given by staff #135 on the day of incident. Staff #115 further stated that resident #004 wanted to remove the protective gear, and that he/she held resident #004's hands to prevent the resident hitting staff #136 and/or taking off the protective gear.

In an interview, staff #107 stated that when resident #004 is having responsive behaviour, staff are to leave and re-approach until she is ready. Staff #107 further stated that there was never pressure to get resident #004 up against his/her will.

In an interview, staff #157 denied having told staff #115 and #107 on the day of incident to use protective gear on the resident and stated that he/she only instructed them to use the protective gear on themselves. Staff #157 further stated that he/she incorrectly documented that he/she had given them these instructions in the progress notes.

In an interview, staff #135 stated that upon her assessment of resident #004 on the above mentioned identified date, the altered skin integrity on resident #004 appeared to be a result of abuse.

In an interview, staff #120 stated that he/she could not verify whether staff were instructed by the management to use a protective gear on resident #004. Staff #120 further stated that this incident would be considered abuse and neglect as staff #115 and #136 had used a protective gear to cover resident #004 when providing care, even when resident #004 exhibited responsive behaviour, causing injury to resident #004.

The severity of this finding is actual harm related to abuse to residents #003 and #004. The scope is an isolated related to residents #003 and #004. Compliance history revealed previous unrelated non-compliance. Due to the severity of this finding, a Compliance Order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, the MOHLTC received a complaint related to improper transfer. The complainant stated that on an identified date, at an identified time, he/she observed staff #147, #148 and #149, transferring resident #021 with an identified type of mechanical lift. The complainant further stated after resident #021 was toileted staff #147 and #148 used an identified alternate type of mechanical lift to provide care to the resident and to transfer resident #021 back to the chair. During this transfer resident #021 was awake, alert and exhibited responsive behaviour and as a result sustained altered skin integrity.

Review of the photographs provided by the complainant revealed altered skin integrity on resident #021.

Review of the progress notes revealed on the above identified date, staff #149 reported to staff #135 that resident #021 sustained an altered skin integrity while being assisted with toileting due to increasing responsive behaviour.

On an identified date, at an identified time the inspector observed staff #147, #148 and #149, using the identified alternate mechanical lift with a support accessory to transfer the resident.

Review of the RAI-MDS completed on an identified date revealed that resident #021 have physical limitation.

Review of the plan of care completed on two identified dates revealed that resident #021 is totally dependent on two staff and required the identified mechanical lifts for all transfers.

In interviews, staff #148 and #149 and #124 stated they were aware resident #021 required the identified mechanical lifts for transfer. Staff #148 and #149 told the inspector that on the above identified date, they used a different type of mechanical lift to provide care to resident #021, as the resident exhibited responsive behaviour on the identified mechanical lift, but did not recall whether the resident sustained altered skin integrity during the transfer. Staff #148 further stated that on the identified date, he/she used a different type of mechanical lift to toilet the resident with the assistance of staff #147 and #149.

In an interview, staff #151 told the inspector that resident #021 requires a specified mechanical lift for all transfers due to physical limitation. Staff #151 further stated that using the different type of mechanical lift was not a safe transfer technique for resident #021 due to his/her physical condition.

In an interview, staff #120 acknowledged that using the different type of mechanical lift to transfer resident #021 was not a safe transfer technique. [s. 36.]

2. On an identified date, the inspector observed staff #111 transfer resident #004 using an identified mechanical lift unassisted by another staff member. After the care was provided, staff #111 and resident #004's SDM transferred resident #004 from the shower chair to the chair using the identified mechanical lift.

Review of the home's Resident Transfer and Lift Procedures, Policy #VII-G-20.20, dated May 2017, revealed an attachment #VII-G-20.20(I) named Mechanical Lifting and Sling Safety Protocol which stated that when a mechanical lift is utilized, two staff members are required to perform the function. It further stated that at no time is it permissible for only one staff to operate a mechanical lift.

In an interview, staff #111 stated that the home's expectation is that two people are to assist with mechanical lifts and that he/she should have asked another staff member for help.

In an interview, staff #151 stated that two staff members are required to assist with mechanical lifts and family members are not to assist.

In an interview, staff #120 stated that the home's expectation is that two trained staff are to assist with mechanical lifts. Staff #120 confirmed that the mechanical transfer of resident #004, performed by staff #111 unassisted on the above mentioned identified date and then with the assistance of a family member were unsafe transfer techniques.

The severity of this finding is actual harm related to improper transfer to resident #021. The scope is a pattern as residents #004 and #021 were found being transferred using unsafe transfer techniques. Compliance history revealed previous non-compliance with voluntary plan of correction of O. Reg. s. 36. Due to the severity of this finding, a Compliance Order is warranted. [s. 36.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, the MOHLTC received a complaint related to continence care and bowel management. The complainant stated that on an identified date, resident #021 was not provided with care for an extended period of time.

On an identified date, at an identified time, the inspector observed staff #131, #137, and #156 provide care to resident #021 in the resident's washroom. Further observation revealed that the resident was not properly cared for.

Review of RAI-MDS completed on an identified date, revealed that resident #021 is incontinent of bowel and bladder.

Review of resident #021's plan of care completed on two identified dates directs the staff to provide specified care at specified times for the resident.

Interviews with staff #131, #137, #147, and #124 revealed that pericare is provided by using a basin, water, soap, and a pericare cloth. Staff #131 confirmed that resident was incontinent of bowel, and he/she did not provide pericare to resident #021 according to the home's protocol.

In an interview, staff #120 stated that the home's expectation is for staff to clean the resident properly to prevent infection and urinary tract infection (UTI). Staff #120 acknowledged resident #021 had not been properly cared for as staff had not followed the above mentioned process when providing pericare to resident #021. [s. 3. (1) 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 the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #4: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date, MOHLTC received a complaint related to unsanitary and unsafe process during care. The complainant stated that on an identified date, at an identified time he/she observed staff #147, #148 and #149, toilet resident #021. The complainant further stated that staff #147 placed the wipes in the sink, put the cleaning solution on top of the wipes and added water, wrung the wipes out, cleaned the resident, and then put the dirty wipes in the sink.

On an identified date, at an identified time, the inspector observed staff #147, #148, and #149 toilet resident #021 in the common washroom. Further observation revealed that staff #147 put water and a pericare cloth in the sink, added soap, and then used the pericare cloth to wash the resident. After cleaning the resident, staff #147 used the hand sanitizer to clean the sink.

In an interview, staff #147 told the inspector that the home's expectation is to clean and sanitize the sink in the common washroom after providing pericare to each resident. He/she confirmed using the hand sanitizer to disinfect the sink.

In an interview, staff #120 told the inspector that when staff use the sink instead of basin to provide pericare and the sink is soiled, the home expects staff use chemicals: "crew solution and one step disinfectant virex II 256" to clean and disinfect the sink. Staff #120 acknowledged that staff #147 had not participated in the implementation of the infection prevention and control program as he/she had used hand sanitizer instead of crew solution and one step disinfectant virex II 256 to disinfect the sink. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

An identified CIS was submitted to the MOHLTC on an identified date related to resident #014's responsive behaviour which involved resident #015. CIS revealed that resident #015 pushed resident #014 resulting in a fall in which resident #014 sustained injury.

Review of the CIS and progress notes for residents #014 and #015 revealed that on the identified date, at an identified time, resident #014 exhibited responsive behaviour which involved resident #015. Staff #123 heard resident #014's yelling and redirected resident #014 away from resident #015. Resident #015 followed resident #014 and staff #123 and pushed resident #014 which caused resident #014 to fall and sustained injury.

Review of resident #014's RAI-MDS completed on an identified date, revealed that resident #014 exhibited responsive behaviour one to three days during the seven days observation period. The same assessment also revealed resident #014's responsive

behaviour was easily altered.

Review of resident #014's triggered listing and resident assessment protocol (RAP) information generated on the identified date revealed that above mentioned responsive behaviour was triggered for resident #014.

Review of resident #014's electronic progress notes on Point Click Care (PCC) revealed that on an identified date, resident #014 was found in an identified area sitting on the floor with part of his/her clothes off. Feces was found on resident #014 and all over the room.

Review of resident #014's written plan of care completed on two weeks after the above mentioned incident, failed to reveal a focus, goal and interventions for the resident's responsive behaviour.

In interviews,staff #111 and #123 stated that resident #014 tended to exhibit identified responsive behaviour since admissions. Staff #111 and #123 further stated that they would give resident #014 activities to occupy the resident when it happened.

In an interview, staff #123 reviewed resident #014's written plan of care and stated that resident #014's identified responsive behaiour was not included in the above mentioned written plan of care.

In an interview, staff #120 stated that the home's expectation is to update the resident's plan of care as per MDS requirement, any significant changes of the resident's condition and any changes of treatment plan. Staff #120 further stated that the written plan of care should also include strategies in managing a resident's responsive behaviour to minimize or de-escalate the risk in related to the resident's responsive behaviour. Staff #120 confirmed that resident #014's written plan of care should have been updated to reflect the resident's responsive behaviour. [s. 6. (1) (a)]

WN #6: 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 that any written complaints that have been received concerning the care of a resident or the operation of the home is immediately forwarded to the Director.

An identified CIS was submitted to the MOHLTC on an identified date, related to an incident which resulted in harm or risk to the resident.

Review of an email record provided by resident #003's SDM revealed that he/she had filed a written complaint about the above mentioned incident to the home on an identified date.

Review of the Complaints Management Program, Policy #XXII-A-10.40, dated August 2016, revealed that in the event of a written complaint, the Executive Director will immediately forward a copy of the complaint to the MOHLTC.

Review of the MOHLT's CIS reporting site, a report was not received by the MOHLTC in relation to this written complaint filed by resident #003's SDM.

In an interview, staff #120 confirmed that the definition of a written complaint includes emails. Staff #120 further confirmed that the written complaint received from resident #003's SDM was not forwarded to the MOHLTC as required. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (1) Every licensee of a long-term care home shall ensure that the requirements of this section are met with respect to every plan of care. O. Reg. 79/10, s. 26 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's cultural, spiritual and religious preferences and age related needs and preferences.

During stage one of the RQI, in an interview, resident #003's SDM stated that he/she was concerned about the lack of assistance that resident #003 received with meals.

On an identified date, resident #003 was observed to be independently eating lunch, and resident #003 ate part of her lunch in a specific manner.

Review of the current plan of care did not reveal indication of resident #003's preference to eat in the specific manner.

In an interview, staff #118 stated that resident #003 eats certain food in the specific manner.

In an interview, staff #133 stated that resident #003 regularly eats in the specific manner as it is part of his/her culture, and when he/she does, the staff tell resident #003 not to eat in the specific manner. Staff #133 further stated that when resident #003 is told not to eat in the specific manner, he/she sometimes gets irritated and leaves the dining room.

In an interview, staff #116 stated that resident #003 prefers to eat in the specific manner as this is how he/she used to eat at home and that it is part of his/her culture. Staff #116 further stated that the staff know resident #003 prefers to eat in the specific manner and that they dis-encourage him/her to do so.

In an interview, staff # 134 stated that staff dis-encourage resident #003 to eat in the specific manner. Staff #134 stated that eating in the specific manner was part of resident #003's culture, and should have been included in his/her plan of care by registered staff.

In an interview, staff #120 confirmed that the home's expectation if staff are aware of a cultural practice or preference that a resident engages in, is to complete an assessment and update the care plan to support the cultural practice. [s. 26. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives fingernail care, including the cutting of fingernails.

As a result of observations during stage one of the RQI, an inspector initiated inspection was conducted related to O. Reg. 79/10, s. 35 (2), related to nail care.

On an identified date, staff #116 and the inspector observed resident #003's fingernails to be long, untrimmed, and dirty with white and brown substances underneath the nails. Two of resident #003's fingernails were broken with sharp edges.

Review of resident #003's current plan of care revealed that under the hygiene focus, resident #003 requires assistance. Interventions related to this focus included checking nails and cleaning twice a day or more often as necessary. Further review of the plan of care revealed that under the bathing focus, resident #003's nails are to be trimmed as required.

Review of the home's Hygiene, Personal Care and Grooming Policy, Policy #VII-G-10.50 dated January 2015, revealed that the PSW is responsible for cleaning resident's fingernails daily.

Review of the documentation survey report for the identified month revealed that resident #003 was provided with a shower on four identified days; however, his/her fingernails were not documented to have been cut on these days.

In an interview, resident #003's SDM stated that the staff do not cut the resident's nails, even though it should be done during showers, and that it results in fungal growth.

In an interview, resident #003 stated that he/she bites her fingernails when they become long.

In an interview, staff #133 stated that staff are to clean resident #003's nails but that he/she does not cut resident #003's nails because of resident #003's medical condition.

In an interview, staff #116 stated that resident #003's fingernails were long, unclean, and needed to be trimmed.

In interviews, staff #116 and #134 stated that fingernail care should have been provided to resident #003 on shower days.

In an interview, staff #120 confirmed that the home's expectation is to provide nail care on shower days as per policy, and if there are challenges, to consult with the family or the registered staff. [s. 35. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home.

As a result of stage one observations during the RQI, the skin and wound inspection protocol was triggered for resident #005.

On an identified date, observations by the inspector revealed an altered skin integrity to resident #005.

Review of the progress notes revealed staff #106 had documented that resident #005 had sustained an altered skin integrity on an identified date.

Review of the home's policy titled: skin and wound care management protocol, policy number VII-G-10.80, revised July 2015, revealed under the procedure section that registered staff will refer the resident to the registered dietitian (RD) for assessment when exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

In an interview, staff #106 stated referrals to the RD for altered skin integrity are completed only if the altered skin integrity is significant and is not healing. Staff #106 further stated he/she had not completed a referral to the RD for resident #005's altered skin integrity.

In an interview, staff #119 stated he/she would typically receive referrals for altered skin integrity and acknowledged that he/she had not received a referral for resident #005.

In an interview, staff #120 acknowledged that resident #005 had not been assessed by the RD when exhibiting altered skin integrity. [s. 50. (2) (b) (iii)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An identified CIS was submitted to the MOHLTC on an identified date related to an incident that resulted in harm or risk to the resident.

Review of the identified CIS stated that on an identified date, resident #003 complained of pain to staff #116 as a result of someone pulling him/her when they were getting him/her up. Resident #003 was unable to identify the individual's name or time of injury. Upon assessment, staff #116 noted that resident #003 sustained altered skin integrity.

The identified CIS was amended five weeks later, and stated that upon investigation, an identified staff member approached resident #003 three times and attempted to guide resident #003 out of bed and resident #003 exhibited responsive behaviour.

Review the amended identified CIS failed to reveal the name of the staff member who was involved in this incident.

In an interview, staff #120 confirmed that the CIS report did not include the name of the identified staff member involved in the incident. [s. 104. (1) 2.]

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

An identified CIS was submitted to the MOHLTC on an identified date related to a fall incident that had occurred five days prior. The CIS revealed resident #009 had experienced a fall which resulted in a transfer to hospital.

Review of resident #009's progress notes revealed an entry on the next day after the incident by the night nurse where he/she had talked to the hospital confirming resident #009 had sustained an injury.

Further review of the CIS revealed it had been submitted to the MOHLTC three days later.

In an interview, staff #120 acknowledged the home had been aware within one business day of resident #009's injury and had failed to inform the Director. [s. 107. (3) 4.]

Issued on this 22nd day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2017_644507_0008
Log No. / No de registre :	013335-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2017
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Bloomington Cove Care Community 13621 Ninth Line, Stouffville, ON, L4A-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANET IWASZCZENKO

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from physical abuse. The plan shall include, but not be limited to the following:

1) The development and implementation of a system of ongoing monitoring to ensure staff respond to residents' resistive of care in a calm and respectful manner as identified in the plan of care, and
2) Provide education to all staff to ensure that staff are able to identify when residents are resistive to care and implement appropriate interventions.

This plan is to be submitted via email to inspector - stella.ng@ontario.ca by August 15, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #003 is protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to an incident that resulted in harm to resident #003.

Review of the above mentioned identified CIS revealed that on the identified date, resident #003 complained of pain to staff #116. Upon assessment, staff #116 noted resident #003 had altered skin integrity. During assessment, resident #003 reported to staff #116 that someone had pulled him/her when he/she was getting up on an identified date. Resident #003 was sent to the hospital for treatment.

During stage one of the Resident Quality Inspection (RQI), prevention of abuse and neglect was triggered for #003 as the resident's substitute decision maker (SDM) relayed the above mentioned incident to the inspector.

Review of resident #003's quarterly Resident Assessment Instrument –Minimum Data Set (RAI-MDS) assessment three weeks prior to the above mentioned incident, revealed that resident #003 had responsive behaviour in the last four to six days, but less than daily, and the behaviour was easily altered.

Review of resident #003's plan of care four days prior to the above mentioned incident, included a focus on the responsive behaviour. The goal for this focus was to reduce incidents of responsive behaviour and to ensure safety for resident and staff. Interventions included allowing resident #003 time to respond to directions, leaving the resident and re-approaching in five to ten minutes.

In an interview, resident #003 stated that a staff member pulled and twisted him/her causing an injury.

In an interview, resident #003's SDM stated that resident #003 told the family that on the above identified date, when he/she was resting, staff #117 asked the resident to get up for meal. Resident #003 told staff #117 that he/she would get up slowly and the staff left. When staff #117 returned, resident #003 was slowly getting up and staff #117 rushed resident #003 and pulled him/her up. Resident #003's SDM further stated the resident's recall of the incident remained consistent on the day of the incident and the day after.

In an interview, staff #117 stated that abuse is when you force the resident to do something they do not want to do. Staff #117 further stated that on the above identified date, he/she called resident #003 for meal when the resident was resting, and staff #117 re-approached the resident three times. On the third approach, he/she forced resident #003 to get up. Staff #117 stated that at this time, resident #003 was exhibiting responsive behaviour, and not wanting to get up.

In an interview, staff #133 provided an example of abuse as trying to force someone to get out of bed when they don't want to. Staff #133 stated that resident #003 only exhibits responsive behaviour if you force him/her to do something he/she does not want to do.

In an interview, staff #134 stated that abuse can be any kind of unwanted physical touch and provided an example of not trying to force a resident to another area if they do not want to go.

In an interview, staff #120 defined abuse as putting a resident at physical risk, including improper or incompetent care that results in harm to the resident. Staff #120 acknowledged that forcing resident #003 to get up was an improper intervention as it could hurt resident #003.

B) Another identified CIS was submitted to the MOHLTC on an identified date, related to an allegation of staff to resident abuse resulting in injury to resident #004. The MOHLTC also received a complaint on the same day from resident #004's SDM of staff allegedly abusing the resident.

Review of the above mentioned CIS revealed that on an identified date, staff #107 observed resident #004 had altered skin integrity. Resident #004 told his/her family staff #136 had abused him/her.

Review of the above mentioned complaint revealed that resident #004's SDM stated resident #004 told the family that on the above mentioned identified date, he/she was being cared for by two staff, and was abused by one of them. Resident #004's SDM further stated that when resident #004 started to cry, the staff used a towel to cover the resident's mouth so that he/she would not make any noise.

In an interview, resident #004's SDM stated that on the above mentioned identified date, resident #004 had exhibited responsive behaviour and when the family visited, the resident had altered skin integrity and the resident was crying, pointing fingers at staff #115 and #136 and stated "he/she abuse me, he/she abuse me".

Review of a social and wellbeing assessment note in the progress notes, dated two months prior to the incident, revealed that resident #004 becomes unhappy if he/she is forced to do something, held tightly, or gets hurt.

Review of resident #004's full MDS admission assessment dated two weeks prior to the incident, revealed that resident #004 was assessed to have responsive behaviour symptom which was not being easily altered.

Review of resident #004's plan of care effective on the date of the incident, revealed a focus on responsive behaviour. The goal for this focus was to ensure safety for resident(s) and staff. The interventions related to this focus included staff to remain cognizant of not invading resident's personal space and to leave resident #004 alone if he/she is showing signs of being upset, and if safe to, re-approach at a later time.

Review of the progress notes on the same date, revealed that staff #136 reported to staff #157 that resident #004 was exhibiting responsive behaviour. Staff #157 instructed staff #136 to don protective gear on him/herself and the resident; however, resident #004 kept removing the protective gear. Further review of the progress notes revealed that on the same day, staff #107 reported the altered skin integrity of resident #004. Resident #004 told his/her family that he/she had been abused by a staff. On assessment, resident #004 had altered skin integrity.

Review of the home's investigation notes revealed the following:
- on an identified date, staff #136 stated that he/she and staff #115 wore protective gear and put one on resident #004 while providing care to resident #004 as instructed on the previous day by the management. Staff #115 was holding resident #004's hands as resident #004 was exhibiting responsive behaviours while the two staff continued to provide care. Staff #136 stated "I can't keep re-approaching, I don't have time. I think this resident thinks I'm the devil."
- two days later, staff #115 and #136 were provided letters of termination by the home as they had been determined to have engaged in the act of resident abuse.

In an interview, staff #115 stated that resident #004 was exhibiting responsive behaviour and the interventions at the time were to wear protective gear, and put one on the resident, as per the instructions given by staff #135 on the day of incident. Staff #115 further stated that resident #004 wanted to remove the protective gear, and that he/she held resident #004's hands to prevent the resident hitting staff #136 and/or taking off the protective gear.

In an interview, staff #107 stated that when resident #004 is having responsive behaviour, staff are to leave and re-approach until she is ready. Staff #107 further stated that there was never pressure to get resident #004 up against

his/her will.

In an interview, staff #157 denied having told staff #115 and #107 on the day of incident to use protective gear on the resident and stated that he/she only instructed them to use the protective gear on themselves. Staff #157 further stated that he/she incorrectly documented that he/she had given them these instructions in the progress notes.

In an interview, staff #135 stated that upon her assessment of resident #004 on the above mentioned identified date, the altered skin integrity on resident #004 appeared to be a result of abuse.

In an interview, staff #120 stated that he/she could not verify whether staff were instructed by the management to use a protective gear on resident #004. Staff #120 further stated that this incident would be considered abuse and neglect as staff #115 and #136 had used a protective gear to cover resident #004 when providing care, even when resident #004 exhibited responsive behaviour, causing injury to resident #004.

The severity of this finding is actual harm related to abuse to residents #003 and #004. The scope is an isolated related to residents #003 and #004. Compliance history revealed previous unrelated non-compliance. Due to the severity of this finding, a Compliance Order is warranted. [s. 19. (1)]
(673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers using mechanical lifting devices, including but not limited to the following:

1) Ensure all staff follow the individual resident's plan of care and home's policy when assisting residents with mechanical lift transfers,
2) Provide education to all direct care staff in mechanical lift transfers, and
3) Implement an auditing system to ensure staff adherence with safe lifting and transferring techniques when assisting residents.

This plan is to be submitted via email to inspector - stella.ng@ontario.ca by August 15, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, the MOHLTC received a complaint related to improper transfer. The complainant stated that on an identified date, at an identified time, he/she observed staff #147, #148 and #149, transferring resident #021 with an identified type of mechanical lift. The complainant further stated after resident #021 was toileted staff #147 and #148 used an identified alternate type of mechanical lift to provide care to the resident and to transfer resident #021 back to the chair. During this transfer resident #021 was awake, alert and exhibited responsive behaviour and as a result sustained altered skin integrity.

Review of the photographs provided by the complainant revealed altered skin integrity on resident #021.

Review of the progress notes revealed on the above identified date, staff #149 reported to staff #135 that resident #021 sustained an altered skin integrity while being assisted with toileting due to increasing responsive behaviour.

On an identified date, at an identified time the inspector observed staff #147, #148 and #149, using the identified alternate mechanical lift with a support accessory to transfer the resident.

Review of the RAI-MDS completed on an identified date revealed that resident #021 have physical limitation.

Review of the plan of care completed on two identified dates revealed that resident #021 is totally dependent on two staff and required the identified mechanical lifts for all transfers.

In interviews, staff #148 and #149 and #124 stated they were aware resident #021 required the identified mechanical lifts for transfer. Staff #148 and #149 told the inspector that on the above identified date, they used a different type of mechanical lift to provide care to resident #021, as the resident exhibited responsive behaviour on the identified mechanical lift, but did not recall whether the resident sustained altered skin integrity during the transfer. Staff #148 further stated that on the identified date, he/she used a different type of mechanical lift to toilet the resident with the assistance of staff #147 and #149.

In an interview, staff #151 told the inspector that resident #021 requires a specified mechanical lift for all transfers due to physical limitation. Staff #151 further stated that using the different type of mechanical lift was not a safe transfer technique for resident #021 due to his/her physical condition.

In an interview, staff #120 acknowledged that using the different type of mechanical lift to transfer resident #021 was not a safe transfer technique. [s. 36.]

2. On an identified date, the inspector observed staff #111 transfer resident #004 using an identified mechanical lift unassisted by another staff member. After the care was provided, staff #111 and resident #004's SDM transferred

resident #004 from the shower chair to the chair using the identified mechanical lift.

Review of the home's Resident Transfer and Lift Procedures, Policy #VII-G-20.20, dated May 2017, revealed an attachment #VII-G-20.20(I) named Mechanical Lifting and Sling Safety Protocol which stated that when a mechanical lift is utilized, two staff members are required to perform the function. It further stated that at no time is it permissible for only one staff to operate a mechanical lift.

In an interview, staff #111 stated that the home's expectation is that two people are to assist with mechanical lifts and that he/she should have asked another staff member for help.

In an interview, staff #151 stated that two staff members are required to assist with mechanical lifts and family members are not to assist.

In an interview, staff #120 stated that the home's expectation is that two trained staff are to assist with mechanical lifts. Staff #120 confirmed that the mechanical transfer of resident #004, performed by staff #111 unassisted on the above mentioned identified date and then with the assistance of a family member were unsafe transfer techniques.

The severity of this finding is actual harm related to improper transfer to resident #021. The scope is a pattern as residents #004 and #021 were found being transferred using unsafe transfer techniques. Compliance history revealed previous non-compliance with voluntary plan of correction of O. Reg. s. 36. Due to the severity of this finding, a Compliance Order is warranted. [s. 36.] (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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