Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2019	2019_769646_0003	024206-17, 025804-17, 001879-18, 004228-18, 007367-18, 008666-18, 009883-18, 009886-18, 017630-18, 021890-18, 025695-18, 026874-18, 026963-18, 027830-18, 028404-18, 002362-19, 002500-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Cheltenham Care Community
5935 Bathurst Street NORTH YORK ON M2R 1Y8

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

IVY LAM (646), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652), PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 4, 5, 6, 7, 8, 11, 12, 13, 14, and 15, 2019.

The following Critical Incident System (CIS) intakes were inspected:
- Log #024206-17 related to financial abuse.
- Logs #025804-17, 021890-18, 027830-18 related to improper transfer.
- Logs #001879-18, and #009883-18 related to staff to resident abuse.
- Logs #004228-18, #025695-18, and #028404-18 related to falls with injury.
- Logs #009886-18, and #017630-18 related to resident to resident abuse.
- Logs #008666-18, #007367-18, #026963-18, and #026874-18 related to injury of unknown case. - Log #002362-19 related to resident elopement
- Log #002500-19 related to self-harm.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Directors of Care (ADOC), the Physiotherapist (PT), Behavioural Support Ontario (BSO) Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, and the front receptionist, and residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions; provision of care, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

9 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 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 used safe transferring and positioning devices or techniques when assisting residents.

This inspection was initiated to inspect on an incident where resident #011 was left suspended in a mechanical lift. Personal Support Worker (PSW) #100 had transferred the resident with a private sitter and had left the resident with the private sitter while the resident was still suspended in the lift.

Review of resident #011's care plan in place for a specified date indicated that resident #011 required an identified level of assistance for toilet use, and required an identified transfer equipment with a specific level of assistance for transfer.

Review of the home's investigation notes indicated that on the day of the incident, PSW #100 had transferred resident #011 with the mechanical lift with resident #011's private sitter. Subsequently, the PSW left the resident suspended on the lift to allow the resident to have a bowel movement.

Review of Assistant Director of Care (ADOC) #103's statement indicated the ADOC had observed resident #011's room door to be opened, and entered the room to observe resident #011 suspended above the identified resident's area with the private sitter in gloves standing by the resident. The ADOC called into the hallway for PSW #100 but could not locate the PSW. After five minutes of waiting, ADOC #103 and the private sitter transferred resident #011 back onto the bed.

In an interview, PSW #100 stated that they had left the room to get an incontinence product for resident #011. They further indicated that they were aware that only registered staff and PSWs who have received training on resident transfer and lifts should transfer residents, and that this was a mistake on the PSW's part.

Interview with ADOC #103 and the Director of Care (DOC) indicated that two trained staff

members of the home should have transferred the resident, and that the PSW should never leave the resident unattended while they are using the identified transfer equipment. The DOC and ADOC #103 further stated that PSW #100 had failed to use safe transferring techniques when assisting resident #011. [s. 36.]

2. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) with regards to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and the resident's progress notes indicated that on an identified date, PSW #141 transferred resident #023 to dining room in an identified mobility device. While the device was in motion, the resident put their feet down, causing pain to an identified area of the resident's body. On the morning of the next day, the staff noted that the resident's condition had changed, and they were not able to get up and to use an identified device independently which they were able to before. Resident was assessed by physiotherapist (PT) who made recommendations including a diagnostic examination. The diagnostic examination result identified an injury.

A review of the resident's Minimum Data Set (MDS) assessment prior the incident indicated the resident needed a specified level of assistance by one staff for transfer, for walking in the room, in the corridor, and for locomotion on the unit. For locomotion off the unit the resident needed another identified level of assistance by using an identified mobility device as the primary mode of locomotion with assistance from the staff.

A review of the resident's health record indicated that the resident was provided a mobility device for temporary use. At the care conference on an identified date, the nurse in charge had communicated with the Substitute Decision Maker (SDM) regarding the need for resident's own identified mobility device and referred the resident to the occupational therapist (OT).

The OT assessed the resident on an identified date and called the SDM to discuss the possibility of ordering their own mobility device for the resident. One week after the call, the OT ordered a new custom mobility device for the resident that arrived two weeks after the order. Based on RN #108's documentation, the mobility device's height appeared to be low for the resident, so the mobility device was left in the resident's room and they continued to use the loaner mobility device. The only information that the resident was using their mobility device was found about four months after the resident's

personal identified mobility device had arrived, one week after the abovementioned incident.

An interview with resident #023 indicated that they had recalled the incident and their injury. The resident indicated that the identified mobility device was loaned and did not have the specific components that a personal mobility device would have. They had to keep their identified part of the body suspended in the air when the staff transferred them on the unit. The resident stated that at the time of the incident, the staff was moving the identified mobility device quickly, and the resident was unable to keep their identified part of the body suspended in the air, so they dropped to the floor. They did not have time to tell the staff that were not able to keep their part of the body suspended in the air, and they sustained the injury.

An interview with PSW #122 indicated that they worked on the day of the incident, and assisted the resident to get ready for an identified mealtime. They assisted the resident with care, transferred them to an identified mobility device and had them outside in the hallway to wait for the next PSW to be brought to the elevator. The PSW #122 confirmed that they did not apply the identified components for the mobility device, as that device was the loaner and did not have those identified components.

An interview with PSW #141 indicated that on the day of the incident, they were scheduled to transfer the resident from the hallway to the elevator where another PSW would take the resident by the elevator to the identified residents' area. The PSW recalled they approached resident #023 that day and notified them that they would push their identified mobility device towards the elevator. The PSW further stated, once they started, the resident put their identified part of the body on the floor and screamed complaining of pain. The PSW denied having moved the mobility device quickly. However they stated when the resident had put their identified part of the body on the floor, this led to a sudden stop with force and the PSW had hit their chest on the handle of the identified mobility device. The PSW also stated that the resident's identified mobility device was a loaner and they did not have the identified components on. The PSW acknowledged transferring the resident without identified components in place was not a safe transfer.

An interview with RN #104 indicated that sometimes the resident did exercises so that was why they did not have the identified components on. However, the RN agreed that transferring the resident with no identified components applied was not a safe transfer. Further, the RN was unable to recall why resident #023 was not using their own identified

mobility device at the time of the incident, or whether the OT was notified to check the identified mobility device.

An interview with PT indicated that they were not aware of the incident as it had happened prior their hiring, however, prior to transferring residents in a identified mobility device the staff was to make sure the identified mobility device was working properly and footrests and/or head support if needed to be positioned according to the resident's needs.

An interview with the DOC indicated that the home had not done investigation about what happened, but they had retrained the frontline staff on the unit for transferring in an identified mobility device, and all staff were trained on falls prevention and safe transfer during the annual training. Further, the DOC acknowledged that using an identified mobility device with no identified components for the feet applied led to an unsafe transfer of resident #023. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

This inspection was initiated to inspect on an incident where resident #011 was left suspended in a mechanical lift. Personal Support Worker (PSW) #100 had transferred

the resident with a private sitter and had left the resident with the private sitter while the resident was still suspended in the lift.

Review of Assistant Director of Care (ADOC) #103's statement indicated the ADOC had observed resident #011's room door to be opened, and entered the room to observe resident #011 suspended above the identified resident's area with the private sitter in gloves standing by the resident.

In an interview, PSW #100 stated that they had left the room to get an incontinence product for resident #011. They further indicated that they were aware that only registered staff and PSWs who have received training on resident transfer and lifts should transfer residents, and that this was a mistake on the PSW's part, and that they had not provided resident #011 with dignity or privacy in providing resident's care.

Interview with ADOC #103 indicated that at the time, the resident did not appear uncomfortable or upset by the incident. Interviews with ADOC #103 and the DOC indicated that PSW #100 had not respected resident #011's rights in providing the resident with dignity and privacy while providing the resident's continence care. [s. 3. (1) 8.]

2. On an identified date during the course of the inspection, Inspector #699 observed the main door an identified resident's room to be fully opened. Inspector #699 observed the door to washroom was open and resident #035 fully unclothed in the washroom while an identified care was being provided by RPN #128. The resident was assisted into a hospital gown and transferred to the identified mobility device outside of the washroom door, with their back exposed to the hallway. PSW #127 entered the room and began to assist RPN #128 with attaching resident to an identified transfer device. RPN #128 then drew back the privacy curtain in the room and closed the door.

In an interview with resident #035, they stated that they prefer to have the door open to both the washroom and main door. They further stated however, when staff are providing them care in the washroom, they will close the door to the washroom to provide care.

In an interview with PSW #127, they stated that in order to ensure a resident's privacy, the door should be closed and the curtain should be drawn. They stated that resident #035 was not provided privacy during their care.

In an interview with RPN #128, they stated that the curtain and door should be closed

when providing care. They stated that resident #025 was not provided privacy during care.

In an interview with the Executive Director (ED), they acknowledged that resident #035 was not provided privacy during their care. [s. 3. (1) 8.]

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 following rights of residents are fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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

This inspection was initiated to inspect on resident #013's fall on an identified date in the resident's room, resulting in an identified injury. At the time of the fall, resident #013 was identified to be wearing regular socks. Review of the CIS report indicated that primary PSW was not aware that non-skid socks were to be applied and did not apply them.

Review of resident #013's care plan that was in place at the time of the incident indicated the resident was at an identified risk for falls and was to be provided with falls prevention interventions, including to ensure the resident is wearing non-skid socks.

Review of the progress notes, the home's investigation notes, and the post fall huddle related to the incident indicated that the resident was found by RPN #105 to have fallen on the floor near the resident's washroom door. The home's investigation notes further indicated that the resident was wearing regular socks rather than non-skid socks.

Review of the post fall huddle indicated the resident stated they had slid on the floor because they were wearing regular socks at the time, and the contributing environmental factor was that the resident wore regular socks at the time.

During the course of the inspection, multiple observations of resident #013 showed that they were provided with and was wearing non-skid socks. Review of the resident's progress notes and physiotherapist notes, and interviews with PSW #106 and ADOC #103 indicated that resident #013's Activities of Daily Living (ADLs) were back to their baseline prior to the fall.

Interview with PSW #106 indicated that at the time of the incident, they had not reviewed the kardex thoroughly prior to working with the resident to see that the resident was to wear non-skid socks, and had provided regular socks instead. The PSW further stated that after the incident, the managers had shown PSW #106 that the non-skid socks had already been in place as a falls prevention intervention in resident #013's care plan and kardex.

Interviews with ADOC #103 and the DOC stated that the PSW did not provide resident #013 with their falls prevention intervention of non-skid socks as specified with resident #013's written plan of care. [s. 6. (7)]

2. The MOHLTC received a CIS report on an identified date related to the elopement of resident #034. Review of the CIS revealed that the resident was noted to be missing around 1400 hours and was last seen at approximately 1300 hours. Resident #034 was then located at an identified intersection outside of the home. The resident was escorted back to the home, one to one staff monitoring was initiated, and pain and head to toe assessments were completed.

Record review of resident #034's clinical health record and review of resident #034's MDS assessment prior to the incident showed that the resident was moderately impaired for cognitive skills for daily decision making.

Review of resident #034's care plan indicated that resident had identified preferred activities that needed to be performed outside of the home, and the staff were to provide assistance as follows:

-RN to give resident the items they need and to check if there are remaining items in their possession or in their identified mobility device;

-Encourage resident to utilize mobile call bell and that the identified activity is to be done in a designated area on the home's property outside;
-Encourage resident to only go off the property with supervision.

Record review of resident #034's progress notes indicated that on the following days, the resident was found outside of the home's premises:

- On the first identified date, at 1135 hours, the resident was found outside the vicinity of the home, near an identified store and had to be escorted back to the home;
-The same identified date at 1715 hours, a code yellow was initiated, the resident was not located inside or outside the home and was found outside the vicinity by the home and was escorted back with no injury;
-Two days later, at 1652 hours, the resident was found outside of the home and walking towards an identified store. The resident appeared confused and did not know where they were and had to be escorted back to the home;
- Three days after the first identified date, at 1400 hours, the resident was observed not be in the home, last seen at 1300 hours, a code yellow was initiated. The resident was later located at an identified area of the home, and stated that they were looking for something to buy, but did not recall that they were staying at the home. The resident was escorted back to the home.
- On the date of the CIS incident, eleven days after the first identified date, at 1640 hours, the resident could not be found after being let out of the front door of the home for their preferred activity, the resident was located at another identified store and was escorted back to the home.

In an interview with RN #102, they stated that resident #034 was safe to conduct their identified preferred activity independently as they were assessed at admission. RN #102 stated that staff will open the front door for the resident so that they can do their preferred activity and is monitored until the resident comes back. They stated that they worked on the identified date of the CIS incident, they let the resident out the front door. They stated for this incident, the care plan was not followed as they should have directed the resident #034 to go to the designated area and provided resident with the mobile call bell.

In an interview with RN# 138, they could not recall if resident had their mobile call bell with them on the first identified date when they eloped from the home.

In an interview with DOC #117, they stated that the care plan was not followed related to resident #034. [s. 6. (7)]

3. On an identified date, a CIS report was submitted to MOHLTC for incident that caused an injury to resident #022 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report indicated that on a specified date, an unidentified staff observed resident #022 was bleeding from an injury. The cause of the injury was not known at that time. The resident was transferred to hospital and returned after treatment was given.

A review of the resident's MDS assessment prior the incident indicated the resident had limitation of the Range of Motion (ROM) and partial loss of the voluntary movement to one side of the body and needed an identified level of extensive assistance by an identified number of staff for bed mobility, required transfer with use of mechanical lift, and assistance with dressing, toilet use, personal hygiene and bathing. Resident #022 was incontinent of bladder and bowel. They did not use the toilet, commode, or urinal, but used incontinent products. Resident also had been identified to be resistive and physically and demonstrated socially inappropriate behaviour that was not easily altered.

A review of the resident's written plan of care prior the incident with the injury to the identified area of their body indicated that the resident needed assistance by staff for activities of daily living. The written plan of care indicated that the resident had resistive behaviors related to discomfort, and one of the interventions to decrease the resistive behaviour was to put the resident in bed early in the evening at an identified time. The resident was assisted back to bed at an identified range of time, and was to be assisted up in the morning between an identified range of time. The resident was to have their incontinent product checked before and after each meal, at bed time and as needed. Peri-care was to be provided at each incontinent change by an identified number of staff members.

In an interview, PSW #107 indicated that when they worked on the date of the incident, they had the resident up, but they did not put the resident back to bed for afternoon rest as they were busy up until the end of their shift. The PSW also stated that they did not provide peri-care or change the incontinent product of the resident for the rest of their shift, indicating the line on the incontinent product did not indicate that the product was wet enough to be changed.

An interview with PSW #142 in afternoon shift indicated that they met the resident in a

hallway in their identified mobility device and checked on the resident. Assuming the day PSW had changed the resident prior the end of their shift, the PSW sent the resident down for the supper meal. After dinner, the PSW stated, they left the resident in the hallway and took them last to be washed and changed, and get to bed for the night. PSW #142 shared that because the resident had expressed resistive and socially inappropriate behaviour, they had to wait for a second staff to assist with the bed time care. The PSW assisted the resident to bed at an identified time, as all the staff were busy until that time.

Observation conducted on two identified dates showed that the resident was not assisted to get out of bed as the written plan of care indicated between the identified range of time. The observation also indicated that the resident was not placed in bed at the identified time as per the plan of care.

An interview with PSW #109 and #110 indicated they get the resident between at an identified time different than the written plan of care and then the evening staff will assist the resident into bed.

An interview with PSW #100 indicated that they do not assist the resident to bed until after an identified meal time. They transfer the resident to bed after dinner, and then they go back to the resident at an identified range of time different from the plan of care to provide bed time care and set the resident for the night.

All interviewed staff were aware of the directions in resident #022's plan of care, however they indicated that it was not always possible to assist the resident as the written plan of care directed them.

In an interview DOC #117 stated that the staff was expected to follow the resident's written plan of care and acknowledged that in providing care to resident #022, the staff did not provide care as it was set out in the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

The MOHLTC received a CIS report on an identified date related to improper/ incompetent treatment of a resident that results in harm or risk to resident #032. Review of the CIS report showed that on an identified date resident #032 reported having pain to

an identified area of their body. The resident reported that when they were transferred out from an identified residents' area on the identified date, and the identified area of their body was observed to be injured. An x-ray on another identified date indicated that resident #032 sustained an identified injury.

Record review of resident #032's full care plan indicated that for locomotion, the resident required identified mobility device for all locomotion and was able to ambulate independently, however if the resident is tired, they required an identified level of assistance.

Record review of resident #032's progress notes showed that the resident was seen by the PT on an identified date prior to the incident and the PT recommended that resident use identified component while they are in the mobility device. Further review of the progress notes showed that identified components were installed by the occupational therapist (OT) to be used when resident is being transferred.

Record review of resident #032's progress showed that five days after the incident, the resident's x-ray results revealed an identified injury. Further review of the progress notes indicated that the physician ordered to provide an identified treatment for the resident for a specified period of time.

Record review of resident #032's care plan did not indicate that the resident had sustained the identified injury, and that identified components were to be used when resident was unable to ambulate independently and required assistance.

In an interview with PSW #132, they stated that if a resident had an injury, they would look into the care plan to identify what the injury was and the interventions related to it. They further stated resident #032 would have the identified components applied during transportation after their identified injury.

In an interview with RPN #130, they stated that resident #032's care plan should have been updated with the injury and use of the identified components during transportation.

In an interview with DOC #117, stated that resident #032's identified injury and use of identified components should have been in either the support actions, medical diagnosis or care plan. The DOC acknowledged resident #032's plan of care was not updated to reflect the above information. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care revised because care set out in the plan had not been effective and different approaches were not considered in the revision of the plan of care.

The MOHLTC received a CIS report on an identified date related to the elopement of resident #034. Review of the CIS revealed that the resident was noted to be missing around 1400 hours and was last seen at approximately 1300 hours. Resident #034 was then located at an identified area off the home's premises. The resident was escorted back to the home, identified staff monitoring was initiated, and identified assessments were completed.

Record review of resident #034's clinical health record and their Minimum Data Set (MDS) assessment at the time indicated that the resident was moderately impaired for cognitive skills for daily decision making.

Record review of resident #034's progress notes indicated that on the following days, the resident was found outside of the home's premises:
- On the first identified date, at 1135 hours, resident was found outside the vicinity of the home, near an identified store and had to be escorted back to the home;
-On the same identified date at 1715 hours, a code yellow was initiated, resident was not located inside or outside the home and was found outside the vicinity by the home and was escorted back with no injury;
-Two days later, at 1652 hours, resident was found outside of the home and walking towards an identified store. The resident appeared confused and did not know where they were and had to be escorted back to the home;
- Three days after the first identified date, at 1400 hours, the resident was observed not be in the home, last seen at 1300 hours, a code yellow was initiated, and the resident was located at an identified area of the home. The resident had stated that they were looking for something to buy, but did not recall that they were staying at the home. The resident was escorted back to the home;
- On the date of the CIS incident, eleven days after the first identified date, at 1640 hours, resident could not be found after being let out of the front door of the home for their preferred activity. The resident was located at another identified store and was escorted back to the home.

Review of resident #034's care plan showed that after the first identified date, the following interventions were initiated:
-Resident to be reminded frequently that identified items are kept at the nurse's station;

-The usual spots they may go to were identified;
-Times of day where there is greater risk for wanting to go out is usually after meals, when they preferred to engage in their preferred activity;
-They have an identified escape-prevention intervention applied to their identified mobility device;
-Usually returns inside within an identified period of time.

Further review of the plan of care did not indicate any further revisions after the first identified incident.

In an interview with Behavioural Supports Ontario (BSO) team leader #139, they stated resident #034 does try to go out of the home and gets disorientated. BSO #139 stated they received a referral for resident #034 four days after the first incident, and have referred resident out for additional behavioural support. They stated that the resident can be redirected easily and that is one of the interventions being utilized for the resident's behaviour. They further stated that they could have had staff go down with the resident when they go down for their identified preferred activity, redirect the resident to engage in the activity at the enclosed area outside of the home, not leave resident in the front of the building without supervision or redirect resident not to engage in their preferred activity at all, as possible interventions to prevent resident from the elopement.

In an interview with RN #138, they stated that elopement is when a resident is unable to be found after searching the inside and outside of the home. RN #138 stated that for resident #034, their care plan should have been reassessed for more interventions as the resident had eloped a few times.

In an interview with DOC #117, they acknowledged that resident #034's plan of care should have been reassessed and updated with interventions related to the resident's elopements. [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:
- The care set out in the plan of care is provided to the resident as specified in the plan;
- The provision of the care set out in the plan of care is documented;
- When the resident's care needs change or care set out in the plan is no longer necessary, the resident is reassessed and the plan of care are reviewed and revised at least every six months and at any other time; and
- 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, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: 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 #021 was protected from abuse by anyone.

Under O. Regulation 79/10, s. 2 (1) for the purpose of the definition "financial abuse" means any misappropriation or misuse of a resident's money or property.

On an identified date, a CIS was submitted to the MOHLTC regarding an allegation of financial abuse of a resident by a staff member.

Review of the CIS report indicated the home received a phone call from resident #021's

family member on an identified date informing the home that a staff member tried to be resident #021's power of attorney and they have handled the resident's finances. Resident #021's family member further stated the staff had borrowed an identified amount of funds from the resident. Further the family member notified the home that prior the resident's hospitalization, the resident told the SDM that they did not feel comfortable with it so they wanted to put their money in a trust account. The family member checked the resident's banking statement and noted a transaction in and out of a large sum of money.

Review of the CIS report and the home's investigation notes indicated that on another identified date, resident #021 was transferred to hospital due to compromised health condition and they expired on an identified date. The resident had been assessed to be cognitively intact. The resident was their own SDM for care and finances. The home contacted the other SDM who confirmed the allegation of the family member. The police were notified of the alleged identified abuse, but the home was told that the police will not start any investigation as the resident is not in the home, but if the family want to submit charges, then the police will contact the family. The home completed their investigation on an identified date and while all of the allegations were not founded, during the course of the investigation, the home discovered other concerns that were outside the scope of the staff responsibility. The home found that some of the staff's actions in relation to resident #021 had crossed professional boundaries. The staff was reprimanded with identified actions for violation of the home policies including Employee Conduct policy and Conflict of Interest policy.

In an interview, housekeeping staff #107 indicated that they had very close relation with resident #021, as the staff felt for the resident due to resident's family issues. The staff denied any of the family's allegation. However, they confirmed that prior to the resident's hospitalization, they took resident #021's identified personal item with an identified sum of money and locked it in their locker as per the resident's request. The staff acknowledged that they should have reported to the nurse and handed over the identified personal item, rather than locking it, and that this was financial abuse.

An interview with the RN #108 confirmed taking a resident's money or belongings is financial abuse.

In an interview, the DOC confirmed that resident #021 was not protected from financial abuse by the staff. [s. 19. (1)]

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 residents are protected from abuse by anyone and are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that police record checks were conducted prior to hiring the identified staff member.

On an identified date, CIS report #0922-000024-17, was submitted to the MOHLTC regarding a financial abuse allegation of resident #021 by staff #107.
A review of the staff's personal file indicated that the staff was hired in the home on an identified date, and no police check was filed.

In an interview, the ED indicated that they are not sure if the police check had been conducted for the identified staff as prior to now, the home was taken over by another company and the police checks were conducted electronically. The ED further stated that the office did not have staff #107's police check in the file, but would ensure the staff provide the police check to the home as soon as possible. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the screening measures shall include police record checks, unless the person being screened is under 18 years of age, to be implemented voluntarily.

WN #6: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was 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 for a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The MOHLTC received a CIS report on an identified date related the elopement of resident #034. Review of the CIS revealed that the resident was noted to be missing at an identified time and was last seen at approximately an hour earlier. Resident #034 was later located in an identified area outside of the home. The resident was escorted back to the home, identified monitoring was initiated, and identified assessments were completed.

Record review of resident #034's clinical health records and the resident's MDS assessment prior to the incident showed that the resident was moderately impaired for cognitive skills for daily decision making.

Record review of resident #034's progress notes revealed that on the following days, the resident was found outside of the home's premises:
- On the first identified date, at 1135 hours, resident was found outside the vicinity of the home, near an identified store and had to be escorted back to the home;
-The same identified date at 1715 hours, a code yellow was initiated, resident was not located inside or outside the home and was found outside the vicinity by the home and was escorted back with no injury.

Review of the home's LTC Summary of Reporting Responsibilities II-G-10.30(a), indicates that a resident who is missing for less than three hours and who returns to the care community with no injury or adverse change in condition regardless of the length of time the resident was missing, a CIS report would be submitted the next business day.

In an interview with DOC #117, they stated that a code yellow was initiated then a CIS report would be have to be submitted. The DOC acknowledged that a report was not submitted for on the abovementioned date, when a code yellow was initiated for resident #034. [s. 107. (3) 1.]

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 Director is informed no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), when a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #7: 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 home has failed to ensure that 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: 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.

This inspection was initiated to inspect on an alleged staff to resident abuse of resident #014 where the family had taken the resident on a leave of absence on an identified date and brought the resident to the hospital four days later, and the nurse at the hospital informed the home that the resident's family member had alleged that staff in the home had beaten the resident.

Review of resident #016's progress notes and the home's investigation notes indicated that RPN #120 was contacted by the registered staff from the hospital four days after the resident's leave of absence. The progress notes further showed that on the identified date, the previous DOC at the time had documented that the DOC had called the hospital to follow up with the nurse who had reported to the home about the allegations made by resident #014's family member.

Review of the home's policy titled Prevention of Abuse & Neglect of a Resident (VII-G-10.00) in place at the time showed that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incidents of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home.

Review of the CIS on the incident, showed that it was submitted to the MOHLTC three days after the call was received from the hospital, and there was no documentation that the after-hours number was called prior to the CIS submission.

Interview with the current DOC indicated the home should have immediately contacted the Director on the day when the hospital had called with the allegations when the home became aware of the allegations of abuse for resident #014, and this was not done. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report included a description of the individuals involved in the incident, including: Names of any staff members or other persons who were present at or discovered the incident.

A CIS was submitted to the MOHLTC related to an incident on an identified date which caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report indicated that nine days prior to the incident, a staff member had assisted resident #023 to an identified residents' area, when suddenly the resident put their identified part of the body on the ground while the identified mobility device was in a motion, and this caused pain to the resident. An injury was identified on an identified area of the resident's body after an x-ray was done. The report was submitted after the home identified the identified injury and the staff involved in the incident. The report did not include the names of the staff members who were present or discovered the incident.

In an interview, the DOC acknowledged that initially it was not known who was the staff involved in the incident and the home did not investigate the incident further, but they focused on the education of the staff on the floor regarding safe transfers. [s. 107. (4) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was created and maintained for each resident of the home.

Record review of the CIS of the identified incident, indicated resident #004 was trying to go inside an identified residents' area and resident #003 was trying to go outside and both residents did not want to let the other pass. Both residents shouted at each other and resident #003 did an action of physical aggression to an identified part of resident #004's body; this was witnessed by a visitor who called the staff and both residents were separated. The CIS also indicated resident #003 was redirected to their room, calmed, Dementia Observational System (DOS) initiated and referral sent to the BSO lead.

Record review of resident #003's progress notes of the incident, indicated that DOS monitoring was initiated for resident #003 on this date.

Record review of resident #003's progress notes on a later date, indicated a DOS summary that mentioned resident #003 was monitored, likes to attend identified activities and after that would stay in an identified residents' area most of the time. However, six days after the incident identified on the CIS, they were verbally aggressive towards other residents and staff in an identified residents' area; with verbal aggression in their native language toward the staff as they wanted to be attended to right away and got upset with co-residents, but was calm throughout the week.

Record review of resident #003 and resident #004's progress notes for the period between the CIS incident to the end of the month, the registered staff indicated in the progress notes that the DOS has been completed for both residents as per the home's

protocol however there were no supporting documentation that the DOS was completed for either residents when the incident occurred in the identified month.

Record review of resident #003's written plan of care indicated DOS monitoring was initiated for seven day on an identified date 17 days before the incident. Record review of resident #003's DOS Form indicated documentation on this form for the first seven days, but there were no DOS monitoring for resident #003 after this period.

Interview with RPN #140 indicated the DOS was completed for resident #003 and resident #004 as mentioned in both residents' progress notes and verified that the DOS documentation could not be found for resident #003 and #004.

Interview with the DOC verified the DOS had not been completed for resident #003 and #004 and the home is implementing a new system for managing the DOS documentation. [s. 231. (a)]

Issued on this 17th day of April, 2019

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

Ministère 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) :	IVY LAM (646), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652), PRAVEENA SITTAMPALAM (699)
Inspection No. / No de l'inspection :	2019_769646_0003
Log No. / No de registre :	024206-17, 025804-17, 001879-18, 004228-18, 007367-18, 008666-18, 009883-18, 009886-18, 017630-18, 021890-18, 025695-18, 026874-18, 026963-18, 027830-18, 028404-18, 002362-19, 002500-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 21, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Cheltenham Care Community 5935 Bathurst Street, NORTH YORK, ON, M2R-1Y8

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Melissa Elliott

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To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:

1) Ensure that for resident #023 and all residents who require a specified transferring or ambulation device have the proper attachments in place at all times unless otherwise specified in the resident's written plan of care.

2) Ensure that staff use safe transferring techniques to assist resident #023 and any other residents who require assistance with transferring as specified in the resident's written plan of care.

3) Develop an auditing system in the home to ensure that resident #023 and all residents who require a specified transferring device have the proper attachments in place when in use.

4) Maintain a written record of audits conducted. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit and the action required as a result of the audit.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) with regards to an incident that caused an

injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and the resident's progress notes indicated that on an identified date, Personal Support Worker (PSW) #141 transferred resident #023 to dining room in an identified mobility device. While the device was in motion, the resident put their feet down, causing pain to an identified area of the resident's body. On the morning of the next day, the staff noted that the resident's condition had changed, and they were not able to get up and to use an identified device independently which they were able to before. Resident was assessed by physiotherapist (PT) who made recommendations including a diagnostic examination. The diagnostic examination result identified an injury.

A review of the resident's Minimum Data Set (MDS) assessment prior the incident indicated the resident needed a specified level of assistance by one staff for transfer, for walking in the room, in the corridor, and for locomotion on the unit. For locomotion off the unit the resident needed another identified level of assistance by using an identified mobility device as the primary mode of locomotion with assistance from the staff.

A review of the resident's health record indicated that the resident was provided a mobility device for temporary use. At the care conference on an identified date, the nurse in charge had communicated with the Substitute Decision Maker (SDM) regarding the need for resident's own identified mobility device and referred the resident to the occupational therapist (OT).

The OT assessed the resident on an identified date and called the SDM to discuss the possibility of ordering their own mobility device for the resident. One week after the call, the OT ordered a new custom mobility device for the resident that arrived two weeks after the order. Based on RN #108's documentation, the mobility device's height appeared to be low for the resident, so the mobility device was left in the resident's room and they continued to use the loaner mobility device. The only information that the resident was using their mobility device was found about four months after the resident's personal identified mobility device had arrived, one week after the abovementioned incident.

An interview with resident #023 indicated that they had recalled the incident and

their injury. The resident indicated that the identified mobility device was loaned and did not have the specific components that a personal mobility device would have. They had to keep their identified part of the body suspended in the air when the staff transferred them on the unit. The resident stated that at the time of the incident, the staff was moving the identified mobility device quickly, and the resident was unable to keep their identified part of the body suspended in the air, so they dropped to the floor. They did not have time to tell the staff that were not able to keep their part of the body suspended in the air, and they sustained the injury.

An interview with PSW #122 indicated that they worked on the day of the incident, and assisted the resident to get ready for an identified mealtime. They assisted the resident with care, transferred them to an identified mobility device and had them outside in the hallway to wait for the next PSW to be brought to the elevator. The PSW #122 confirmed that they did not apply the identified components for the mobility device, as that device was the loaner and did not have those identified components.

An interview with PSW #141 indicated that on the day of the incident, they were scheduled to transfer the resident from the hallway to the elevator where another PSW would take the resident by the elevator to the identified residents' area. The PSW recalled they approached resident #023 that day and notified them that they would push their identified mobility device towards the elevator. The PSW further stated, once they started, the resident put their identified part of the body on the floor and screamed complaining of pain. The PSW denied having moved the mobility device quickly. However they stated when the resident had put their identified part of the body on the floor, this led to a sudden stop with force and the PSW had hit their chest on the handle of the identified mobility device. The PSW also stated that the resident's identified mobility device was a loaner and they did not have the identified components on. The PSW acknowledged transferring the resident without identified components in place was not a safe transfer.

An interview with RN #104 indicated that sometimes the resident did exercises so that was why they did not have the identified components on. However, the RN agreed that transferring the resident with no identified components applied was not a safe transfer. Further, the RN was unable to recall why resident #023

was not using their own identified mobility device at the time of the incident, or whether the OT was notified to check the identified mobility device.

An interview with PT indicated that they were not aware of the incident as it had happened prior their hiring, however, prior to transferring residents in a identified mobility device the staff was to make sure the identified mobility device was working properly and footrests and/or head support if needed to be positioned according to the resident's needs.

An interview with the Director of Care (DOC) indicated that the home had not done investigation about what happened, but they had retrained the frontline staff on the unit for transferring in an identified mobility device, and all staff were trained on falls prevention and safe transfer during the annual training. Further, the DOC acknowledged that using an identified mobility device with no identified components for the feet applied led to an unsafe transfer of resident #023.

The severity of this issue was determined to be a level 3 as there was actual harm to resident. The scope was a level 1 isolated, as the risk of harm was related to one of the resident living in the home area. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
- Voluntary Plan of Correction issued December 28, 2016 (#2016_252513_0011). (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 21st day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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