Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Jan 27, 2021	2020_715672_0021	010079-20, 012060-20, 014150-20, 015797-20, 016354-20, 017604-20, 019604-20, 020543-20, 020708-20, 020713-20, 022918-20, 023808-20	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive Oshawa ON L1G 8E3

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

JENNIFER BATTEN (672), SAMI JAROUR (570)

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): December 3, 4, 7, 8, 9, 14, 15, 16, 17, 21 and 22, 2020

The following intakes were completed during this inspection:

Two intakes related to resident falls which resulted in fractures and significant changes in condition
Five intakes related to incidents of resident to resident physical abuse
Five intakes related to incidents of staff to resident abuse and/or neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care, RAI Coordinator, Behavioural Support Ontario Lead (BSO RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Physiotherapists (PT) and physio assistants (PTA), Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Pain Management and Responsive Behaviours. The Inspector (s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

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

10 WN(s)
7 VPC(s)
3 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 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 #010 was free from neglect by the staff in the home.

For the purposes of the Act and Regulation, “Neglect” is defined as:

“the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.” O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse/neglect, involving resident #010 and Personal Care Provider (PCP) #100. The CIR indicated PCP #100 removed the call bell from resident #010’s reach at their bedside, and taped the resident’s call bell in their bathroom to the wall, so that neither of the call bells could be accessed by the resident.

Inspector reviewed the internal investigation notes into the incident, which indicated that PCP #100 acknowledged that they placed the call bell out of reach for the resident.

PCP #100 was not available for interview during the inspection.

During an interview, PCP #104 indicated upon entering resident #010’s bedroom they noted that the call bell at the resident’s bedside had been removed from the resident’s reach and the call bell in the bathroom had been taped to the wall, so that the resident could not access or utilize it.

During an interview, the Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) indicated that resident #010 had identified responsive behaviours, therefore

identified interventions were documented in the resident's written plan of care for staff to implement as required.

During an interview, the Administrator indicated an internal investigation had been completed with findings that PCP #100 had admitted to removing the call bell at the bedside from resident #010's reach and had taped the call bell in the resident's bathroom with tape, in order to render the call bell unusable. PCP #100 indicated the decision had been made due to resident #010 exhibiting responsive behaviours which included frequently pulling the call bell, and they wanted to stop the behaviour. The Administrator further indicated that the expectation in the home was for residents to have access to their call bells at all times for safety reasons and depriving a resident of the ability to contact staff when required was considered an act of abuse and neglect.

Sources: Internal investigation notes from the incident, Critical Incident Report, resident #010's written plan of care, interviews with PCP #104, the BSO RPN and Administrator. [s. 19. (1)]

2. The licensee has failed to ensure that resident #001 was free from abuse by the staff in the home.

For the purposes of the Act and Regulation, "Verbal Abuse" is defined as:

"any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #001 and Personal Care Provider (PCP) #100. The CIR indicated PCP #100 was providing care to resident #001 when the resident became resistive and aggressive and started to strike out at the staff member. PCP #100 was then noted to grab resident #001 tightly by their hands in order to restrain the resident and raised their voice at the resident.

PCP #100 was not available for interview during the inspection.

During record review, Inspector noted resident #001 had identified responsive behaviours, which had identified interventions for staff to implement. Review of the internal investigation indicated that PCP #100 acknowledged they had grabbed resident

#001 by their hands in order to restrain them and raised their voice to the resident.

During an interview, PCP #103 indicated PCP #100 was assisting with providing care to resident #001 and was observed to “forcefully” grab the resident by their hands and restrain the resident, then “screamed” in the resident’s face to ‘stop it’, when the resident became resistive during care.

During an interview, the BSO RPN indicated that resident #001 had identified responsive behaviours therefore identified interventions were documented in the resident’s written plan of care for staff to implement as required. The BSO RPN further indicated it was never an acceptable option for staff to physically restrain or raise their voice to a resident.

During an interview, the Administrator indicated the expectation in the home was for each staff member to be familiar with every resident’s plan of care that they were providing care for and it was not acceptable for a staff member to restrain a resident’s hands or raise their voice to a resident.

Sources: Internal investigation notes from the incident, Critical Incident Report, resident #001’s written plan of care, interviews with PCP #103, the BSO RPN and Administrator. [s. 19. (1)]

3. The licensee has failed to ensure that resident #002 was free from abuse by the staff in the home.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #002 and PCP #100. The CIR indicated that PCP #100 was providing care to resident #002, when the resident became resistive to care and verbally aggressive to the staff member, using profanities. PCP #100 responded with the same profanities in a raised voice.

PCP #100 was not available for interview during the inspection.

During record review, Inspector noted resident #002 had identified responsive behaviours.

During an interview, PCP #101 indicated that PCP #100 was assisting with providing care to resident #002, when the resident became resistive to care and verbally

aggressive to the staff member, using profanities and PCP #100 responded with the same profanities in a raised voice.

During an interview, the BSO RPN indicated that resident #002 had identified responsive behaviours, therefore identified interventions were documented in the resident's written plan of care for staff to implement as required. The BSO RPN further indicated that it was never an acceptable option for staff to raise their voice or name call to a resident.

During an interview, the Administrator indicated it was not acceptable for a staff member to raise their voice or name call to a resident.

Sources: Internal investigation notes from the incident, Critical Incident Report,, resident #002's written plan of care, interviews with PCP #101, the BSO RPN and Administrator. [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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the internal fall prevention policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal falls prevention policy provided instructions for the registered staff to follow in the event of a resident fall, with identified steps to follow. The registered staff did not follow these directions after resident #016 sustained the fall.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016, which resulted in an injury.

Inspector reviewed resident #016's assessments, progress notes, written plan of care and noted the registered staff did not assess the resident afterwards for any possible injury or negative outcome, the incident was not passed along to the oncoming staff during shift report, a post fall huddle was not conducted and resident #016's POA was not notified of the fall until the following day. Inspector also noted that a Post Fall Assessment and Analysis, Pain Assessment and Skin Assessment had not been completed on the date of the fall. Inspector then reviewed resident #016's written plans of care and noted there were no revisions between them, related to fall prevention interventions, pain management, or the resident's injury.

During separate interviews, RPN #120 and the DOC indicated that following a resident fall, registered staff were supposed to follow the directions listed within the internal fall prevention policy, which had not been done after the fall sustained by resident #016. By failing to ensure that the internal resident fall prevention program was complied with, the resident was placed at increased risk of sustaining further falls, uncontrolled pain, having an undiagnosed injury and negative outcomes.

Sources: Resident #016's written plan of care, internal fall prevention policy and interviews with RPN #122 and the DOC. [s. 8. (1) (a),s. 8. (1) (b)]

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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #016.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016 which resulted in an injury. According to the CIR, resident #016 was receiving a shower while in a shower chair with the assistance of staff, when the fall occurred. The staff members immediately assisted resident #016 up from the floor and completed the shower, then reported the incident to the charge nurse.

During a resident observation, Inspector was informed it was resident #016's regular shower day, and staff were preparing to use the shower chair they "always" used to shower the resident. Inspector noted that staff were using the chair the resident had been using at the time of the fall, and the chair did not appear to have a seat belt in place for staff to utilize. Inspector then observed the other shower chairs in the home and noted that none of them appeared to have seat belts in place for staff to use when residents were seated in them.

Inspector reviewed the user manual for the shower chair which indicated the chair was delivered with a seat belt in place and that "the user should always wear the provided seat belt for safety while sitting in the commode".

During an interview, resident #016 indicated the shower commode chair was the regular chair staff used when assisting the resident in the shower.

During an interview, PCP #120 indicated they were the staff member assigned to

resident #016 that shift, had worked with and provided showers to the resident in the past, and had always utilized the identified shower commode when showering the resident. PCP #120 further indicated they were unaware of any of the shower chairs/commodes in the home having seat belts in place, as they had been informed that any seat belt was considered a restraint, therefore seat belts were not used in the home at all.

During separate interviews, PCP #121 and RPN #122 indicated the identified shower commode was not an appropriate shower chair for staff to use when assisting resident #016 in the shower for specified reasons. RPN #122 indicated the shower commode had also not been an appropriate chair choice for the resident on the date the fall occurred. PCP #121 and RPN #122 indicated they were unaware of any of the shower chairs/commodes in the home having seat belts in place, as any seat belt was considered a restraint, whether the resident could undo them or not.

Sources: Shower commode user manual, interviews with resident #016, PCPs #120, #121 and RPN #122. [s. 23.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 failed to ensure that resident #014 was groomed and cared for in a manner which was consistent with their needs.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse which occurred between PCP #123 and resident #014.

During an interview, resident #014 indicated they had a previous history with PCP #123 prior to the incident which occurred, regarding continence care. Resident #014 alleged that when PCP #123 was on duty and they would ring for assistance to have their incontinent product changed, PCP #123 would frequently refuse to change the product and would tell the resident that their incontinent product was not soiled enough for it to be changed, as staff had been directed that all incontinent products must be at a minimum of 75% soiled before being allowed to change the product. This also resulted in times when PCP #123 would put the old incontinent product back on the resident after providing peri care. Resident #014 indicated they had complained about this multiple times to the charge nurses, but no changes had been made.

During separate interviews, PCPs #105, #120 and #123 indicated that the home had changed to a new continence care provider within the last year or so, and staff had received education and direction that incontinent products were not to be changed unless they were at a minimum of 75% soiled.

During separate interviews, the DOC and Administrator indicated the home had changed to a new continence care provider, but staff had not received direction that incontinent products were only supposed to be changed once they were at a minimum of 75% soiled. The DOC and Administrator stated the expectation in the home was for staff to assist residents with changing their incontinent products upon request.

Sources: Interviews with resident #014, PCPs #105, #120 and #123, the DOC and Administrator. [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 residents are groomed and cared for in a manner which is consistent with their needs, 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016's plan of care provided clear directions to staff regarding which shower chair was safe for staff to use with the resident.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016 which resulted in an injury.

During a resident observation, Inspector was informed it was resident #016's regular shower day and staff were preparing to use the shower chair they "always" used to shower the resident. Upon inspection, it was noted that staff were using an identified shower commode, which was the chair the resident had been using at the time of the fall which resulted in an injury.

During an interview, resident #016 indicated the shower commode chair was the regular chair staff used when assisting the resident in the shower.

During an interview, PCP #120 indicated they were the staff member assigned to resident #016 that shift, had worked with resident #016 in the past and provided showers to the resident, and had always utilized the identified shower commode when showering the resident.

During separate interviews, PCP #121 and RPN #122 indicated each resident's written plan of care should indicate which shower/bath chair staff were supposed to use for the resident so that incorrect equipment was not used in error, as had occurred with resident #016, but was unaware if the information was present in resident #016's written plan of care.

During record review, Inspector reviewed resident #016's specified written plans of care and noted they did not outline if any equipment was required to shower/bath the resident and if so, which equipment. By failing to ensure the resident's plan of care provided direction to staff regarding which shower chair was safe for the resident to utilize, the resident was placed at risk of physical harm from falling from the shower chair.

Sources: Resident #016's written plans of care, interviews with resident #016, PCPs #120, #121 and RPN #122. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in resident #003's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse, involving residents #003 and #004. The CIR indicated resident #003 was observed approaching resident #004 and initiated an argument which ended in an altercation. The CIR further indicated that resident #003 had been involved in an identified number of incidents, therefore had a specified intervention implemented.

The internal investigation notes and incident report indicated the specified intervention was not implemented at the time the incident occurred.

During separate interviews, the Administrator, DOC and BSO RPN indicated the expectation in the home was for staff to provide care to each resident as specified in their plan of care. By not ensuring that resident #003 had the specified intervention

implemented as directed in their plan of care, other residents were placed at risk.

Sources: Identified Critical Incident Report, resident #003's plan of care, incident report and internal investigation notes into the incident and interviews with the Administrator, DOC and BSO RPN. [s. 6. (7)]

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 plans of care provide clear directions to staff and are provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy which promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #001 and PCP #100.

During record review, Inspector noted the incident was not called into the Director until the day after the alleged incident.

Review of the internal prevention of abuse policy indicated 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 must be immediately reported.

During an interview, PCP #103 indicated they did not report the allegation of abuse from PCP #100 towards resident #001 until the following day. PCP #103 further indicated they had received education in the home related to the internal abuse policy and was aware the expectation was for any allegation of resident abuse or neglect to be immediately reported to their supervisor.

During an interview, the Administrator indicated the expectation in the home was for staff to immediately report any allegation of resident abuse or neglect to their supervisor. The Administrator further indicated that every staff member had received education on the internal abuse policy, which included the reporting requirements.

Sources: Internal investigation notes from the incident, internal prevention of abuse policy, identified critical incident report, interviews with PCP #103 and Administrator. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy which promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #002 and PCP #100.

During record review, Inspector noted the incident was not called into the Director until the following day.

During an interview, PCP #101 indicated they did not report the allegation of staff to resident abuse until the following day. PCP #101 further indicated they had received education in the home related to the internal abuse policy and was aware the expectation was for any allegation of resident abuse or neglect to be immediately reported to their supervisor.

Sources: Internal investigation notes from the incident, internal prevention of abuse policy, identified critical incident report, interviews with PCP #101 and Administrator. [s. 20. (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 written policy which promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #016's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016 which resulted in an identified injury.

During an interview, resident #016 indicated they had complaints of pain on a daily basis.

During record review, Inspector reviewed resident #016's progress notes and physician's orders from a specified period of time, which indicated that since the date of the fall, the resident had frequent complaints of pain that ranged in severity on the pain scale.

At the time of the fall, resident #016 had a physician's order for an analgesic which was not effective in managing the resident's pain. During a specified period of time, the resident received an identified number of different physician's orders to assist with pain

control, with varying degrees of effectiveness.

Review of resident #016's specified electronic Medication Administration Records (eMARs) indicated that between a specified period of time, the resident received an identified number of medications for complaints of pain. Following the administration of multiple doses of specified medications, resident #016 was noted to still have complaints of pain.

During separate interviews, PCPs #120, #121 and RPN #122 indicated resident #016 had frequent complaints of pain throughout the day, which had not been present prior to the fall. PCPs #120 and #121 further indicated the resident would often refuse personal care and meals due to their pain and would request to have breakthrough medications administered, which would at times not be effective. RPN #122 indicated the expectations in the home was for pain assessments to be completed upon admission to the home and then on a quarterly basis; following a fall; with any new analgesic order; if breakthrough medications were used for more than three days and/or were not effective; and for any new complaint of pain.

Inspector reviewed the internal pain management policy which provided directions regarding when staff were to complete a new Comprehensive Pain Assessment Tool.

Inspector reviewed resident #016's current written plan of care and noted there was no focus specific to the resident's pain. Inspector then reviewed the pain assessments completed for the resident between a specified period of time and noted an identified number of assessments completed, which did not meet the directions provided in the internal pain management policy.

During an interview, the DOC verified the expectations in the home was for pain assessments to be completed as indicated in the internal policy. The DOC further indicated that pain assessments should have been completed for resident #016 at specified times. By failing to ensure that resident #016's pain was assessed, the resident was at increased risk of having uncontrolled pain which could lead to negative effects on their appetite, food and fluid intake, bed mobility, toileting habits, attitude and enjoyment of life.

Sources: Resident #016's written plan of care; specified physician's orders, progress notes and eMARs; internal pain management policy; interviews with resident #016, PCPs #120, #121, RPN #122 and the DOC. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for that purpose, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff documented the effectiveness of resident #003's interventions, when specified assessment forms were not completed in full.

During an identified period of time, a specified number of critical incident reports were submitted to the Director related to allegations of resident to resident abuse, involving resident #003.

During record review, Inspector noted that resident #003 had been placed on an identified assessment a specified number of times. Inspector reviewed the documentation for each of the assessments and noted that every assessment had gaps of missing documentation.

During an interview, the BSO RPN indicated the expectation in the home was for staff to complete the assessments according to the directions listed on the assessment form. The BSO RPN further indicated the staff members in the home had received several training sessions related to how and when to complete the identified assessment, along with the importance of having accurate data documented. Lastly, the BSO RPN indicated they were aware that there had been issues in the past with staff not completing the assessments according to the directions and not having the outcomes of the assessments analyzed. In response to this, they had initiated a new plan of reviewing the assessments.

During an interview, the Administrator indicated the expectation in the home was for staff to complete assessments according to the directions listed on the assessment form and was aware that had not been occurring consistently. The Administrator further indicated they believed a strong leadership team was now in place, and they had come up with ideas and a plan for ensuring interventions were implemented as required for the residents and that staff documented the effectiveness of those interventions in the resident's health care record. By not ensuring that staff documented the effectiveness of resident #003's implemented interventions, the residents of the home were placed at risk of further incidents occurring.

Sources: Identified assessments for resident #003, interviews with the BSO RPN and Administrator. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the effectiveness of resident's interventions are documented as required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training in the required areas, according to the legislation, before performing their responsibilities.

During an identified period of time, a specified number of critical incident reports were submitted to the Director related to allegations of resident to resident abuse, involving resident #003, therefore a specified intervention was implemented which involved staff from a third party agency.

During an interview, staff member #112 indicated they had not received education/training/orientation related to all areas required under the legislation. Inspector then followed up with an identified number of staff members from the third party agency working in the home, who indicated they had not received any orientation or education on all of the policies required according to the legislation prior to working in the home.

During an interview, the Administrator indicated that it was possible staff working in the home through a third party agency had not received orientation and/or the education required under the legislation prior to performing their responsibilities in the home. The Administrator further indicated they were aware of the requirements related to orientation and education of staff prior to having them perform any duties and work in the home.

Sources: Review of the ‘orientation duotang’ present at an identified nursing station, interviews with staff members from the third party agency and the Administrator. [s. 76. (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 staff receive training in the required areas, according to the legislation, before performing their responsibilities in the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #014's SDM was notified of the results of the alleged abuse investigation immediately upon the completion.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse. According to the CIR, the licensee was notified by resident #014's Substitute Decision Maker (SDM) the resident alleged that when they were receiving personal care from PCP #123, an incident had occurred.

During an interview, resident #014 was able to recall and recount the alleged incident to the Inspector as was outlined in the CIR.

Inspector reviewed the internal investigation notes, progress notes and Risk Management reports related to the alleged incident and did not observe any documentation which indicated that resident #014's SDM received any follow up communication after the internal investigation was completed, to notify them of the outcome and findings.

During an interview, the Director of Care (DOC) indicated they had conducted the internal investigation after being notified by the resident's SDM of the alleged incident. The DOC further indicated they had not communicated the outcome of the internal investigation to resident #014's SDM, as they had accidentally forgotten to do so, but were aware of the legislative requirements which directed that resident's SDMs were to be notified of the results of the alleged abuse investigation immediately upon completion.

Sources: Interviews with resident #014 and the DOC, review of the internal investigation notes, identified critical incident report, resident #014's progress notes and the Risk Management report. [s. 97. (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 resident's SDMs are notified of the results of any alleged abuse investigations immediately upon completion, to be implemented voluntarily.

Issued on this 27th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672), SAMI JAROUR (570)
Inspection No. / No de l’inspection :	2020_715672_0021
Log No. / No de registre :	010079-20, 012060-20, 014150-20, 015797-20, 016354-20, 017604-20, 019604-20, 020543-20, 020708-20, 020713-20, 022918-20, 023808-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Wynfield Long Term Care Residence 451 Woodmount Drive, Oshawa, ON, L1G-8E3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sam Rahaman

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 must be compliant with section s. 19 (1).

Specifically, the licensee must:

1. Educate PSW #100 on the internal policy entitled "Abuse Free Communities – Prevention, Education and Analysis"; policy number: LTC-CA-WQ-100-05-18; Effective Date: July 2010; Last Revised: July 2016 and responsive behaviours policy. Test the PSW's knowledge and keep a documented record of the process.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #010 was free from neglect by the staff in the home.

For the purposes of the Act and Regulation, "Neglect" is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse/neglect, involving resident #010 and Personal Care Provider (PCP) #100. The CIR indicated PCP #100 removed the call bell from resident #010's reach at their bedside, and taped the resident's call bell in their bathroom to the wall, so that neither of the call bells could be accessed by the resident.

Inspector reviewed the internal investigation notes into the incident, which indicated that PCP #100 acknowledged that they placed the call bell out of reach for the resident.

PCP #100 was not available for interview during the inspection.

During an interview, PCP #104 indicated upon entering resident #010's bedroom they noted that the call bell at the resident's bedside had been removed from the resident's reach and the call bell in the bathroom had been taped to the wall, so that the resident could not access or utilize it.

During an interview, the Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) indicated that resident #010 had identified responsive behaviours, therefore identified interventions were documented in the resident's written plan of care for staff to implement as required.

During an interview, the Administrator indicated an internal investigation had been completed with findings that PCP #100 had admitted to removing the call bell at the bedside from resident #010's reach and had taped the call bell in the resident's bathroom with tape, in order to render the call bell unusable. PCP #100 indicated the decision had been made due to resident #010 exhibiting responsive behaviours which included frequently pulling the call bell, and they wanted to stop the behaviour. The Administrator further indicated that the expectation in the home was for residents to have access to their call bells at all times for safety reasons and depriving a resident of the ability to contact staff when required was considered an act of abuse and neglect.

Sources: Internal investigation notes from the incident, Critical Incident Report, resident #010's written plan of care, interviews with PCP #104, the BSO RPN and Administrator. (672)

2. 2. The licensee has failed to ensure that resident #001 was free from abuse by the staff in the home.

For the purposes of the Act and Regulation, "Verbal Abuse" is defined as:

"any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #001 and Personal Care Provider (PCP) #100. The CIR indicated PCP #100 was providing care to resident #001 when the resident became resistive and aggressive and started to strike out at the staff member. PCP #100 was then noted to grab resident #001 tightly by their hands in order to restrain the resident and raised their voice at the resident.

PCP #100 was not available for interview during the inspection.

During record review, Inspector noted resident #001 had identified responsive behaviours, which had identified interventions for staff to implement. Review of the internal investigation indicated that PCP #100 acknowledged they had grabbed resident #001 by their hands in order to restrain them and raised their voice to the resident.

During an interview, PCP #103 indicated PCP #100 was assisting with providing care to resident #001 and was observed to "forcefully" grab the resident by their hands and restrain the resident, then "screamed" in the resident's face to 'stop it', when the resident became resistive during care.

During an interview, the BSO RPN indicated that resident #001 had identified responsive behaviours therefore identified interventions were documented in the resident's written plan of care for staff to implement as required. The BSO RPN further indicated it was never an acceptable option for staff to physically restrain or raise their voice to a resident.

During an interview, the Administrator indicated the expectation in the home was for each staff member to be familiar with every resident's plan of care that they were providing care for and it was not acceptable for a staff member to restrain a resident's hands or raise their voice to a resident.

Sources: Internal investigation notes from the incident, Critical Incident Report,

resident #001's written plan of care, interviews with PCP #103, the BSO RPN and Administrator.
(672)

3. The licensee has failed to ensure that resident #002 was free from abuse by the staff in the home.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse involving resident #002 and PCP #100. The CIR indicated that PCP #100 was providing care to resident #002, when the resident became resistive to care and verbally aggressive to the staff member, using profanities. PCP #100 responded with the same profanities in a raised voice.

PCP #100 was not available for interview during the inspection.

During record review, Inspector noted resident #002 had identified responsive behaviours.

During an interview, PCP #101 indicated that PCP #100 was assisting with providing care to resident #002, when the resident became resistive to care and verbally aggressive to the staff member, using profanities and PCP #100 responded with the same profanities in a raised voice.

During an interview, the BSO RPN indicated that resident #002 had identified responsive behaviours, therefore identified interventions were documented in the resident's written plan of care for staff to implement as required. The BSO RPN further indicated that it was never an acceptable option for staff to raise their voice or name call to a resident.

During an interview, the Administrator indicated it was not acceptable for a staff member to raise their voice or name call to a resident.

Sources: Internal investigation notes from the incident, Critical Incident Report,, resident #002's written plan of care, interviews with PCP #101, the BSO RPN and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to the residents, as multiple residents were subjected to incidents of neglect and abuse.
.
Scope: The scope of this non-compliance was widespread, as three residents were affected.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2021

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with section s. 8 (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Educate RPN #122 and PSWs #124 and #125 on the internal policy entitled "Resident Fall Prevention Program"; policy number: LTC-CA-WQ-200-07-08; effective date: February 2007; revision date: June 2019. Test the retention of this knowledge and a documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the internal fall prevention policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal falls prevention policy provided instructions for the

registered staff to follow in the event of a resident fall, with identified steps to follow. The registered staff did not follow these directions after resident #016 sustained the fall.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016, which resulted in an injury.

Inspector reviewed resident #016's assessments, progress notes, written plan of care and noted the registered staff did not assess the resident afterwards for any possible injury or negative outcome, the incident was not passed along to the oncoming staff during shift report, a post fall huddle was not conducted and resident #016's POA was not notified of the fall until the following day. Inspector also noted that a Post Fall Assessment and Analysis, Pain Assessment and Skin Assessment had not been completed on the date of the fall. Inspector then reviewed resident #016's written plans of care and noted there were no revisions between them, related to fall prevention interventions, pain management, or the resident's injury.

During separate interviews, RPN #120 and the DOC indicated that following a resident fall, registered staff were supposed to follow the directions listed within the internal fall prevention policy, which had not been done after the fall sustained by resident #016. By failing to ensure that the internal resident fall prevention program was complied with, the resident was placed at increased risk of sustaining further falls, uncontrolled pain, having an undiagnosed injury and negative outcomes.

Sources: Resident #016's written plan of care, internal fall prevention policy and interviews with RPN #122 and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to the resident, as they sustained a fracture and experienced uncontrolled pain.

Scope: The scope of this non-compliance was isolated, as only one resident was affected.

Compliance History: Two previous voluntary plans of compliance (VPCs) were issued to the home in the past 36 months related to this area of the legislation. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with section s. 23.

Specifically, the licensee must:

1. Ensure that all positioning devices in the home are equipped and used according to the instructions provided by the manufacturer.

2. Ensure that resident #016 has the correct positioning device identified in their plan of care.

3. Ensure that every PSW staff member who assists residents with bathing are aware of the guidelines and restrictions for use of each of the positioning devices used during baths and showers. Keep a documented record of the education completed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #016.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #016 which resulted in a fractured left femur. According to the CIR, resident #016 was receiving a shower while in a shower chair with the assistance of two staff members, when the resident slid out of the chair to the floor. The staff members immediately assisted resident #016 back into the shower chair and completed the shower, then reported the incident to the charge nurse.

During a resident observation, Inspector was informed it was resident #016's regular shower day, and staff were preparing to transfer the resident into the shower chair they "always" used to shower the resident, which was already present in the resident's bedroom, awaiting transfer of the resident. Inspector noted that staff were using the EZee Life 190/195 tilt shower commode, which was the chair the resident had been using at the time of the fall on November 21, 2020, and the chair did not appear to have a seat belt in place for staff to utilize. Inspector then observed the other shower chairs in the home and noted that none of them appeared to have seat belts in place for staff to use when residents were seated in them.

Inspector reviewed the "EZee Life 190/195 Tilt Shower Commode User Manual" which indicated the chair was delivered with a seat belt in place and that "the user should always wear the provided seat belt for safety while sitting in the commode".

During an interview, resident #016 indicated the shower commode chair parked at their bedside was the regular chair staff used when assisting the resident in the shower.

During an interview, PCP #120 indicated they were the staff member assigned to resident #016 that shift, had worked with and provided showers to the resident in the past, and had always utilized the EZee Life shower commode when showering the resident. PCP #120 further indicated they were unaware of any of the shower chairs/commodes in the home having seat belts in place, as they had been informed that any seat belt was considered a restraint, therefore seat belts were not used in the home at all.

During separate interviews, PCP #121 and RPN #122 indicated the EZee Life 190/195 tilt shower commode was not an appropriate shower chair for staff to use when assisting resident #016 in the shower, as the resident did not have sufficient upper body strength/control to utilize the chair. RPN #122 indicated the EZee Life shower commode had also not been an appropriate chair choice for the resident on November 21, 2020. PCP #121 and RPN #122 indicated they were unaware of any of the shower chairs/commodes in the home having seat belts in place, as any seat belt was considered a restraint, whether the resident could undo them or not.

Sources: "EZee Life 190/195 Tilt Shower Commode User Manual", interviews with resident #016, PCPs #120, #121 and RPN #122.

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to the resident, as they sustained a fracture and experienced uncontrolled pain.

Scope: The scope of this non-compliance was isolated, as only one resident was affected.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2021

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 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 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 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 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 27th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office