Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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
Jul 16, 2019	2019_263524_0022	001751-18, 005343-18, 016024-18, 018474-18, 021364-18, 026473-18, 030194-18, 032018-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Langstaff Square Care Community
170 Red Maple Road RICHMOND HILL ON L4B 4T8

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

INA REYNOLDS (524), AMBERLY COWPERTHWAITE (435), CHERYL MCFADDEN (745), JULIE LAMPMAN (522)

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): July 2, 3, 4 and 5, 2019.

The following Critical Incidents were completed within the inspection:
Log #001751-18 / CIS #2907-000001-18 related to the prevention of abuse and neglect
Log #005343-18 / CIS #2907-000004-18 related to the prevention of abuse and neglect and responsive behaviours
Log #016024-18 / CIS #2907-000013-18 related to prevention of abuse and neglect
Log #018474-18 / CIS #2907-000014-18 related to the prevention of abuse and neglect and responsive behaviours
Log #021364-18 / CIS #2907-000016-18 related to prevention of abuse and neglect
Log #026473-18 / CIS #2907-000018-18 related to falls prevention
Log #030194-18 / CIS #2907-000028-18 related to falls prevention
Log #032018-18 / CIS #2907-000030-18 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, one Registered Nurse, five Registered Practical Nurses, five Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions,
reviewed residents' clinical records including assessments and care planning interventions,
the home's investigation notes, staff education records and reviewed relevant policies and procedures related to this inspection.

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

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10, s. 48. (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10, s. 30 (1) states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

The home's "Falls Prevention and Management" policy #VII-G-30.10 with a revision date of April 2019, stated in part,
"The Nurse will conduct a falls risk assessment at the following times:
- Within 24 hours of move in or on return from hospital;
- As triggered by the MDS Resident Assessment Protocol;
- A significant change in status i.e. when there is a psychological, functional, or cognitive

change in status."

"When a fall occurs, the nurse will complete a post falls assessment and head injury assessment as required."

"Post fall assessment: The Nurse will:
- Initiate a head injury routine if a head injury is suspected, or if the resident falls is unwitnessed and he/she is on anticoagulant therapy.
- Monitor head injury as per the schedule on the form post-fall for signs of neurological changes i.e. facial droop, behavioural changes, weakness on one side etc.
- Conduct a thorough investigation of the fall incident, including all contributing factors.
- Complete a post-fall assessment (available electronically as the Post Fall Incident Form)."

Review of the home's "Head Injury Routine" policy #VII-G-30.20 with a revision date of April 2019, stated in part, "The Director of Care or Designate will ensure Head Injury Routine (HIR) will be initiated on any resident who has sustained or is suspected of sustaining a head injury, and after any unwitnessed resident fall. Complete HIR as per the schedule outlined or as ordered by the physician."

Review of the Head Injury Monitoring Record noted that, "Head Injury Routine is done 15 minutes for an hour, q 30 min X 2 hours, q 1 hour x 3 hours, q 2 hours x 8 hours and q 4 hours x 12 hours or until directed by the physician to cease monitoring."

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on an identified date, related to the unwitnessed fall of resident #005 which resulted in an injury.

Review of the resident's electronic clinical record in Point Click Care (PCC) noted a Quarterly Falls Risk Assessment on a specific date. A review of the Falls Risk Assessment noted the assessment was blank.

In an interview, Assistant Director of Care (ADOC) #106 stated that a Falls Risk Assessment should be completed for a resident quarterly if triggered by the Minimum Data Set (MDS) Assessment. ADOC #106 reviewed the resident's quarterly Falls Risk Assessment for a specific date, with inspector. ADOC #106 acknowledged that the Falls Risk Assessment had not been completed for the resident, as required and that the assessment should have been completed.

A review of the resident's electronic clinical record noted that the resident also had an unwitnessed fall on an other identified date that resulted in an injury.

A review of the resident's Head Injury Routine (HIR) for a specific date, noted the assessment was initiated at a specific hour. The two hour assessment scheduled for a specific hour, noted the resident as "sleeping". There was no HIR documented for that time.

In an interview, Registered Nurse (RN) #109 acknowledged that the HIR for the specific date and time was not completed for the resident. RN #109 stated they would not rouse a resident if they were sleeping but would take the resident's vitals.

In an interview, Assistant Director of Care (ADOC) #106 acknowledged that the HIR should have been completed for the resident.

B) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, the resident went to the bathroom on their own and fell. When staff entered the bathroom the resident was found on the floor. The CIS indicated that the resident sustained an injury with altered skin integrity. The CIS report noted that the resident had numerous falls in the quarter prior to their fall that was identified on the CIS report.

Review of the resident's electronic clinical record noted the resident had additional falls on multiple identified dates. All of the resident's falls were unwitnessed except the fall on a specific date.

In an interview, Registered Practical Nurse (RPN) #105 stated a Head Injury Routine (HIR) Assessment would be completed if a resident had an unwitnessed fall or if a resident fell and hit their head. RPN #105 stated all HIR Assessments were completed on paper and filed in the resident's hard copy chart.

A review of the resident's hard copy HIR Assessments noted the following:
- On a specific date, a HIR assessment was initiated at a specific hour. The assessments scheduled for multiple identified hours, noted the resident as "sleeping". The assessment at a specific hour, noted "sleeping" under vitals, verbal response, motor response, pupils and limb movement.

- On a specific date, a HIR assessment was initiated at a specific hour. The scheduled assessments for multiple hours noted "sleeping" under vital signs, pupils and limb movement.
- On a specific date, a HIR assessment was initiated at a specific hour. The scheduled assessment at an identified hour noted "sleeping".
- On a specific date, a HIR assessment was initiated at a specific hour. The resident's pupils and limb movement were not checked every 15 minutes and every 30 minutes at multiple identified times. The resident was noted as "sleeping" at multiple hours.
- There were no documented HIR Assessments for the resident for multiple dates.

In an interview, RPN #112 acknowledged that the HIR Assessments for the resident were not documented for the identified dates.

In an interview, Assistant Director of Care (ADOC) #106 acknowledged that the HIR Assessments should have been completed for resident #004 and registered staff should have attempted to rouse the resident if they were sleeping to complete the HIR Assessment.

C) A review of a Fall Incident for a specific date, in risk management in Point Click Care (PCC) noted resident #004 had an unwitnessed fall. The Fall Incident report indicated that resident #004 was found by staff. Further review of the Fall Incident noted the contributing factors of the fall was left blank.

In an interview, ADOC #106 reviewed resident #004's Fall Incident and Post Fall Incident Form for the specific date, and acknowledged that the fall incident was not completed in full and contributing factors should have been completed and if there were none identified staff should have ticked off "none" on the incident form.

The licensee has failed to ensure that the home's "Falls Prevention and Management" policy and "Head Injury Routine" policy was complied with.

The severity of this issue was determined to be a level 3, actual risk. The scope of the issue was a level 2 a pattern, as it related to two of four residents reviewed. The home had a level 3 history as they had previous noncompliance with this section of the LTCHA that included: Written Notification and Voluntary Plan of Correction issued on February 16, 2017, (2016_405189_0020). [s. 8. (1) (a),s. 8. (1) (b)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, resident #004 had a fall and staff found them on the floor. The CIS and review of the resident's Post Fall Incident Form for a specific date, indicated that resident #004 sustained an identified injury and altered skin integrity.

Review of resident #004's electronic clinical record in Point Click Care (PCC) noted no

documented skin and wound assessments for the injury and altered skin integrity.

In an interview, Registered Practical Nurse #105 stated that all skin assessments were completed under the assessment tab in PCC. RPN #105 reviewed resident #004's electronic clinical record in PCC with inspector and confirmed that resident #004 did not receive a skin and wound assessment for the altered skin integrity. RPN #105 stated there were no documented skin assessments in resident #004's chart.

In an interview, Assistant Director of Care (ADOC) #106 stated that resident #004 should have received a skin and wound assessment for the identified injury and altered skin integrity.

The licensee has failed to ensure that resident #004 who sustained an injury and altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, resident #004 was found by staff on the floor. The CIS and review of the resident's Post Fall Incident Form for a specific date, indicated that resident #004 sustained an identified injury and altered skin integrity to specific parts of their body.

Review of resident #004's electronic clinical record in Point Click Care (PCC) noted no documented referral to a registered dietitian or assessment by a registered dietitian for resident #004's altered skin integrity.

In an interview, Registered Practical Nurse #105 stated that if a resident had altered skin integrity, they would make a referral to the dietitian in PCC. RPN #105 reviewed resident #004's electronic clinical record in PCC and confirmed that there was no referral made to the dietitian related to resident #004's altered skin integrity. RPN #105 stated that resident #004 should have had an assessment by the dietitian and that there was no evidence of an assessment in resident #004's clinical record.

In an interview, Assistant Director of Care (ADOC) #106 stated that resident #004 should have received an assessment from a registered dietitian for the altered skin integrity.

The licensee has failed to ensure that resident #004 who sustained altered skin integrity to specific parts of their body, was assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the unwitnessed fall of resident #005 which resulted in the resident sustaining a specific injury and altered skin integrity.

A review of resident #005's electronic clinical record in Point Click Care (PCC) noted that resident #005 also had an unwitnessed fall on another identified date. A review of the Fall Incident in risk management for a specific date, noted the resident's injury and altered skin integrity.

In an interview, Registered Nurse (RN) #109 stated that resident skin and wound assessments were completed electronically in PCC.

Review of resident #005's electronic clinical record in PCC noted a Skin and Wound Care Assessment on a specific date. The assessment noted a description and measurement of the injury and altered skin integrity to specific areas of their body.

Further review of resident #005's clinical record noted no weekly skin and wound assessments for the injury.

In an interview, Registered Nurse (RN) #109 stated that resident skin and wound assessments were completed electronically in PCC.

In an interview, Assistant Director of Care (ADOC) #106 reviewed resident #005's skin assessments in PCC with inspector. ADOC #106 acknowledged that resident #005 did not receive a weekly skin and wound assessments for the injury and altered skin integrity. ADOC #106 stated that weekly skin and wound assessments should have been

completed for resident #005.

The licensee has failed to ensure that resident #005 who had an injury and altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The severity of this issue was determined to be a level 2, minimal harm/risk. The scope of the issue was a level 2 a pattern, as it related to two of four residents reviewed. The home had a level 3 history as they had previous noncompliance with this section of the LTCHA that included: Written Notification and Voluntary Plan of Correction issued on February 16, 2017, (2016_405189_0020). [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was first reported to the Ministry of Health and

Long-Term Care (MOHLTC) on a specific date, related to a fall sustained by resident #001 which resulted in resident #001 being transferred to hospital with an injury. The CIS report continued to state that the immediate actions and interventions that were in place prior to the critical incident occurring was that resident #001 was educated on the use of their personal assistive service device (PASD) and call bell placed within reach.

Review of resident #001's Fall Risk Assessment for a specific date, documented that resident #001 was at risk for falls. Review of progress note for a specific date, documented that resident #001 had sustained a fall in a specific area of the home. The note continued to state in part that the immediate actions that were taken to prevent a recurrence were to monitor resident #001 closely, and to ensure that the resident used their PASD when ambulating.

Review of resident #001's care plan with a specific initiated date, documented under a physiotherapy focus that resident #001 was at an increased risk of falls. This focus continued to document under the approaches and support actions section "To monitor for falls and apply all possible fall prevention measures to prevent falls."

In an interview with Registered Practical Nurse (RPN) #110, when asked what interventions they would expect to be in place for a resident who was identified as a fall risk on assessment, RPN #110 identified multiple specific interventions that they would expect a resident to have in place.

In an interview with Assistant Director of Care (ADOC) #106, when asked what they would expect to be instituted for a resident with a risk for falls upon assessment, ADOC #106 identified multiple interventions that they would expect to have in place. When asked where staff were expected to look to find the interventions that were in place related to resident #001's falls prevention and management, ADOC #106 stated the care plan kardex. ADOC #106 stated that the care plan found on PointClickCare (PCC) auto populated the kardex that staff would reference. When asked if "all possible fall prevention measures to prevent falls" identified in resident #001's care plan at the time of their fall provided clear direction to staff on what interventions were to be applied for resident #001, ADOC #106 stated that it was vague.

The licensee had failed to ensure that there was a written plan of care for resident #001 that set out clear direction to staff and others who provided direct care to resident #001 for their falls prevention and management interventions. [s. 6. (1) (c)]

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

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the unwitnessed fall of resident #005 which resulted in the resident sustaining an injury and altered skin integrity.

A review of resident #005's most recent care plan in Point Click Care (PCC) noted resident #005 was a risk for falls and the resident was to have a specific personal assistive service device (PASD) in place when the resident was up and seated as a fall prevention intervention.

On a specific date and time, resident #005 was observed in the hallway on an identified home area. Resident #005 was seated and the specific PASD was not in place. Inspector called Registered Nurse (RN) #109 who was in the hallway giving out medications at that time. RN #109 stated that resident #005 should have the PASD on when they were up and put the PASD in place for resident #005.

In an interview, Assistant Director of Care (ADOC) #106 stated resident #005 should have a specific PASD on whenever they were up and seated, as per their plan of care.

The licensee has failed to ensure that the care set out in the plan of care related to falls prevention was provided to resident #005 as specified in the plan. [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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident; and, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

A) Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, resident #004 had a fall and staff found them on the floor. The CIS and review of resident #004's Post Fall Incident Form for a specific date, indicated that resident #004 sustained an injury and altered skin integrity to specific areas of their body.

Review of the home's Skin and Wound Care Management Protocol Policy #VII-G-10.92 with a revision date of May 2019, stated in part, with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the nurse "will update the plan of care, including the Treatment Administration Record and care plan as appropriate."

Review of resident #004's electronic clinical record in Point Click Care (PCC) noted no documentation in resident #004's electronic Treatment Administration Record (eTAR), doctor's orders or care plan regarding the injury and altered skin integrity to resident #004's specific areas of their body.

In an interview, Registered Practical Nurse (RPN) #105 stated that there was a medical directive for altered skin integrity and registered staff would need to enter the information in the doctor's orders to show on a resident's eTAR for treatment and dressing changes. RPN #105 also stated that registered staff would need to update the resident's care plan if the resident had any altered skin integrity.

In an interview, Assistant Director of Care (ADOC) #106 reviewed resident #004's

electronic chart with inspector and acknowledged that there was no documentation in resident #004's plan of care related to the injury and altered skin integrity and stated that it should have been included in their plan of care.

B) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the unwitnessed fall of resident #005 which resulted in the resident sustaining a injury and altered skin integrity.

A review of resident #005's electronic clinical record in Point Click Care (PCC) noted that resident #005 also had an unwitnessed fall on a specific date. A review of the Fall Incident in risk management, noted a specific injury and altered skin integrity.

Review of the home's Skin and Wound Care Management Protocol Policy #VII-G-10.92 with a revision date of May 2019, stated in part, with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the nurse "will update the plan of care, including the Treatment Administration Record and care plan as appropriate."

Review of resident #005's electronic clinical record in Point Click Care (PCC) noted no documentation in resident #005's electronic Treatment Administration Record (eTAR), doctor's orders or care plan regarding the injury and altered skin integrity.

In an interview, Registered Practical Nurse (RPN) #105 stated that there was a medical directive for altered skin integrity and registered staff would need to enter the information in the doctor's orders to show on a resident's eTAR for treatment and dressing changes. RPN #105 also stated that registered staff would need to update the resident's care plan if the resident had any altered skin integrity.

In an interview, Assistant Director of Care (ADOC) #106 reviewed resident #005's electronic chart with inspector and acknowledged that there was no documentation in resident #005's plan of care related to resident #005's altered skin integrity. ADOC #106 stated they had entered a progress note related to the altered skin integrity and acknowledged that there was no other documentation. ADOC #106 stated that staff would be treating the injury and there should have been an order and the treatment should have been entered in resident #005's eTAR.

The licensee has failed to ensure that resident #004 and #005's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's skin condition,

including altered skin integrity. [s. 26. (3) 15.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's skin condition, including altered skin integrity, to be implemented voluntarily.

WN #5: 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. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in any other areas provided for in the regulations, at times or at intervals provided for in the regulations.

Ontario Regulation 79/10, 221 (1) states, “For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.”

Ontario Regulation 79/10, 221 (2) states, “The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

In an interview, inspector requested the training records for direct care staff related to falls prevention and management and skin and wound care from Assistant Director of Care (ADOC) #106. ADOC #106 stated that staff completed training annually online through Relias.

Review of the Relias training records from 2018 noted the following:
- 11 out of 107 (10.2 %) direct care staff did not complete training on fall prevention and management.
- 8 out of 139 (5.75 %) direct care staff did not complete training on skin and wound care.

ADOC #106 acknowledged that not all direct care staff had received training on fall prevention and management and skin and wound care in 2018.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in fall prevention and management and skin and wound care. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in any other areas provided for in the regulations, at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Specifically, the licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident and reported to the Director.

A Critical Incident System (CIS) report was first reported to the Ministry of Health and Long-Term Care (MOHLTC) on specific date, related to an incident of suspected abuse of resident #008. The CIS report stated in part that resident #008 had sustained specific injuries, identified by Personal Support Worker (PSW) #114. The family was notified and on an unidentified date the family had concerns related to abuse. A care conference was planned. During review of the CIS report, it was identified that the initial investigation was initiated and resident #008 was assessed for injury. Review of the CIS did not identify the outcome of the investigation or care conference.

In an interview with Director of Care (DOC) #101, when asked who completed amendments for CIS reports, DOC #101 stated that the DOC or Associate Directors of Care (ADOCs) do. When asked if the CIS was amended, DOC #101 stated no it had not been amended. When asked if the CIS included the date family concerns of abuse were brought forward, DOC #101 stated no. When asked, DOC #101 stated the CIS had not included the name of the staff member being moved to a different unit. When asked what education was completed by the staff member, DOC #101 did not know what education was completed. When asked, DOC#101 stated the home should have investigation notes in the home for this incident but they did not.

In an interview with ADOC #106 when asked if the home's investigations notes for the CIS were completed, and included dates, time, staff interviewed and outcomes, they stated no it was not completed.

Inspector reviewed the Long-Term Care Homes.net used by the home to report incidents to the Director, and found no amended CIS report.

After multiple requests over a period of four days from inspectors regarding the investigation and the outcome of this CIS report, management was unable to provide this information to inspector. No staff members were able to speak to the incident.

The licensee failed to ensure that the outcome of the investigation for the CIS was reported to the Director which failed to include, amendments, investigation notes, outcomes of care conference and investigation, staff member names, education completed and date of concern from the family. [s. 23. (2)]

Issued on this 29th day of July, 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

Ministère de la Santé et 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 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) :	INA REYNOLDS (524), AMBERLY COWPERTHWAITE (435), CHERYL MCFADDEN (745), JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_263524_0022
Log No. / No de registre :	001751-18, 005343-18, 016024-18, 018474-18, 021364-18, 026473-18, 030194-18, 032018-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Langstaff Square Care Community 170 Red Maple Road, RICHMOND HILL, ON, L4B-4T8
	Dwayne Green

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Name of Administrator / Nom de l’administratrice ou de l’administrateur :

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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 s. 8. (1)(b) of Ontario Regulation 79/10. Specifically, the licensee must ensure that:
a) the home's "Falls Prevention and Management" and "Head Injury Routine" policy is complied with.
b) the home shall audit to ensure the policies are complied with and keep a record of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10, s. 48. (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10, s. 30 (1) states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and

objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

The home's "Falls Prevention and Management" policy #VII-G-30.10 with a revision date of April 2019, stated in part,
"The Nurse will conduct a falls risk assessment at the following times:
- Within 24 hours of move in or on return from hospital;
- As triggered by the MDS Resident Assessment Protocol;
- A significant change in status i.e. when there is a psychological, functional, or cognitive change in status."

"When a fall occurs, the nurse will complete a post falls assessment and head injury assessment as required."

"Post fall assessment: The Nurse will
- Initiate a head injury routine if a head injury is suspected, or if the resident falls is unwitnessed and he/she is on anticoagulant therapy.
- Monitor head injury as per the schedule on the form post-fall for signs of neurological changes i.e. facial droop, behavioural changes, weakness on one side etc."
- Conduct a thorough investigation of the fall incident, including all contributing factors.
- Complete a post-fall assessment (available electronically as the Post Fall Incident Form)."

Review of the home's "Head Injury Routine" policy #VII-G-30.20 with a revision date of April 2019, stated in part, "The Director of Care or Designate will ensure Head Injury Routine (HIR) will be initiated on any resident who has sustained or is suspected of sustaining a head injury, and after any unwitnessed resident fall. Complete HIR as per the schedule outlined or as ordered by the physician."

Review of the Head Injury Monitoring Record noted, "Head Injury Routine is done 15 minutes for an hour, q 30 min X 2 hours, q 1 hour x 3 hours, q 2 hours x 8 hours and q 4 hours x 12 hours or until directed by the physician to cease monitoring."

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on an identified date, related to the unwitnessed fall of resident #005 which resulted in an injury.

Review of the resident's electronic clinical record in Point Click Care (PCC) noted a Quarterly Falls Risk Assessment on a specific date. A review of the Falls Risk Assessment noted the assessment was blank.

In an interview, Assistant Director of Care (ADOC) #106 stated that a Falls Risk Assessment should be completed for a resident quarterly if triggered by the Minimum Data Set (MDS) Assessment. ADOC #106 reviewed the resident's quarterly Falls Risk Assessment for a specific date, with inspector. ADOC #106 acknowledged that the Falls Risk Assessment had not been completed for the resident, as required and that the assessment should have been completed.

A review of the resident's electronic clinical record noted that the resident also had an unwitnessed fall on an other identified date that resulted in an injury.

A review of the resident's Head Injury Routine (HIR) for a specific date, noted the assessment was initiated at a specific hour. The two hour assessment scheduled for a specific hour, noted the resident as "sleeping". There was no HIR documented for that time.

In an interview, Registered Nurse (RN) #109 acknowledged that the HIR for the specific date and time was not completed for the resident. RN #109 stated they would not rouse a resident if they were sleeping but would take the resident's vitals.

In an interview, Assistant Director of Care (ADOC) #106 acknowledged that the HIR should have been completed for resident #005.

B) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004.

Review of the CIS report indicated that on a specific date, the resident had a fall and staff found them on the floor. The CIS indicated that the resident sustained

an injury with altered skin integrity. The CIS report noted that the resident had numerous falls in the quarter prior to their fall that was identified on the CIS report.

Review of the resident's electronic clinical record noted the resident had additional falls on multiple identified dates. All of the resident's falls were unwitnessed except the fall on a specific date.

In an interview, Registered Practical Nurse (RPN) #105 stated a Head Injury Routine (HIR) Assessment would be completed if a resident had an unwitnessed fall or if a resident fell and hit their head. RPN #105 stated all HIR Assessments were completed on paper and filed in the resident's hard copy chart.

A review of the resident's hard copy HIR Assessments noted the following:
- On a specific date, a HIR assessment was initiated at a specific hour. The assessments scheduled for multiple identified hours, noted the resident as "sleeping". The assessment at a specific hour, noted "sleeping" under vitals, verbal response, motor response, pupils and limb movement.
- On a specific date, a HIR assessment was initiated at a specific hour. The scheduled assessments for multiple hours noted "sleeping" under vital signs, pupils and limb movement.
- On a specific date, a HIR assessment was initiated at a specific hour. The scheduled assessment at an identified hour noted "sleeping".
- On a specific date, a HIR assessment was initiated at a specific hour. The resident's pupils and limb movement were not checked every 15 minutes and every 30 minutes at multiple identified times. The resident was noted as "sleeping" at multiple hours.
- There were no documented HIR Assessments for the resident for multiple dates.

In an interview, RPN #112 acknowledged that the HIR Assessments for the resident were not documented for the identified dates.

In an interview, Assistant Director of Care (ADOC) #106 acknowledged that the HIR Assessments should have been completed for resident #004 and registered staff should have attempted to rouse the resident if they were sleeping to complete the HIR Assessment.

C) A review of a Fall Incident for a specific date, in risk management in Point Click Care (PCC) noted resident #004 had an unwitnessed fall. The Fall Incident report indicated that resident #004 was found by staff. Further review of the Fall Incident noted the contributing factors of the fall was left blank.

In an interview, ADOC #106 reviewed resident #004's Fall Incident and Post Fall Incident Form for the specific date, and acknowledged that the fall incident was not completed in full and contributing factors should have been completed and if there were none identified staff should have ticked off "none" on the incident form.

The licensee has failed to ensure that the home's "Falls Prevention and Management" policy and "Head Injury Routine" policy was complied with.

The severity of this issue was determined to be a level 3, actual risk. The scope of the issue was a level 2 a pattern, as it related to two of four residents reviewed. The home had a level 3 history as they had previous noncompliance with this section of the LTCHA that included: Written Notification and Voluntary Plan of Correction issued on February 16, 2017, (2016_405189_0020). (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

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 # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with r. 50 (2) (b) of Ontario Regulation 79/10.
Specifically, the licensee must ensure that:
a) resident #004 and any other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
b) resident #004 and any other residents are assessed by a registered dietitian who is a member of the staff of the home.
c) resident #005 and any other residents are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, resident #004 had a fall and staff found them on the floor. The CIS and review of the resident's Post Fall Incident Form for a specific date, indicated that resident #004 sustained an identified injury and altered skin integrity.

Review of resident #004's electronic clinical record in Point Click Care (PCC) noted no documented skin and wound assessments for the injury and altered skin integrity.

In an interview, Registered Practical Nurse #105 stated that all skin assessments were completed under the assessment tab in PCC. RPN #105 reviewed resident #004's electronic clinical record in PCC with inspector and confirmed that resident #004 did not receive a skin and wound assessment for the altered skin integrity. RPN #105 stated there were no documented skin assessments in resident #004's chart.

In an interview, Assistant Director of Care (ADOC) #106 stated that resident #004 should have received a skin and wound assessment for the identified injury and altered skin integrity.

The licensee has failed to ensure that resident #004 who sustained an injury and altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)] (522)

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

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the fall of resident #004. Review of the CIS report indicated that on a specific date, resident #004 was found by staff on the floor. The CIS and review of the resident's Post Fall Incident Form for a specific date, indicated that resident #004 sustained an identified injury and altered skin integrity to specific parts of their body.

Review of resident #004's electronic clinical record in Point Click Care (PCC) noted no documented referral to a registered dietitian or assessment by a registered dietitian for resident #004's altered skin integrity.

In an interview, Registered Practical Nurse #105 stated that if a resident had altered skin integrity, they would make a referral to the dietitian in PCC. RPN #105 reviewed resident #004's electronic clinical record in PCC and confirmed that there was no referral made to the dietitian related to resident #004's altered skin integrity. RPN #105 stated that resident #004 should have had an assessment by the dietitian and that there was no evidence of an assessment in resident #004's clinical record.

In an interview, Assistant Director of Care (ADOC) #106 stated that resident #004 should have received an assessment from a registered dietitian for the altered skin integrity.

The licensee has failed to ensure that resident #004 who sustained altered skin integrity to specific parts of their body, was assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)] (522)

3. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specific date, related to the unwitnessed fall of resident #005 which resulted in the resident sustaining a specific injury and altered skin integrity.

A review of resident #005's electronic clinical record in Point Click Care (PCC) noted that resident #005 also had an unwitnessed fall on another identified date. A review of the Fall Incident in risk management for a specific date, noted the resident's injury and altered skin integrity.

In an interview, Registered Nurse (RN) #109 stated that resident skin and wound assessments were completed electronically in PCC.

Review of resident #005's electronic clinical record in PCC noted a Skin and Wound Care Assessment on a specific date. The assessment noted a description and measurement of the injury and altered skin integrity to specific areas of their body.

Further review of resident #005's clinical record noted no weekly skin and wound assessments for the injury.

In an interview, Registered Nurse (RN) #109 stated that resident skin and wound assessments were completed electronically in PCC.

In an interview, Assistant Director of Care (ADOC) #106 reviewed resident #005's skin assessments in PCC with inspector. ADOC #106 acknowledged that resident #005 did not receive a weekly skin and wound assessments for the injury and altered skin integrity. ADOC #106 stated that weekly skin and wound

assessments should have been completed for resident #005.

The licensee has failed to ensure that resident #005 who had an injury and altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The severity of this issue was determined to be a level 2, minimal harm/risk. The scope of the issue was a level 2 a pattern, as it related to two of four residents reviewed. The home had a level 3 history as they had previous noncompliance with this section of the LTCHA that included: Written Notification and Voluntary Plan of Correction issued on February 16, 2017, (2016_405189_0020). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 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 16th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ina Reynolds

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