Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2016	2016_226192_0014	007242-16	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

DEBORA SAVILLE (192), ALISON FALKINGHAM (518), REBECCA DEWITTE (521), SHERRI COOK (633)

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

This Critical Incident Inspection was completed concurrently with Complaint Inspection number 2016_226192_0014.

Non-compliance identified in this inspection related to O.Reg 79/10 s. 8(1)(b;

LTCHA 2007, S.O. 2007, chapter 8, s.24(1) and s.20(1) will be issued in the report for Complaint Inspection 2016_226192_0013.

Critical Incidents inspected included:
log 000806-15 - CI 2789-000001-15
log 001332-15 - CI 2789-000008-15
log 007242-16 - CI 2789-000010-16
log 007515-16 - CI 2789-000011-16
log 007710-16 - CI 2789-000012-16
log 004314-15 - CI 2789-000028-15
log 019802-15 - CI 2789-000059-15 and 2789-000047-15
log -22223-15 - CI 2789-000062-15
log 004656-16 - CI 2789-000008-16
log 023067-15 - CI 2789-000068-15
log 008661-16 - CI 2789-000015-16
log 032840-15 - CI 2789-000099-15; 2789-000100-15; 2789-000092-15 and 2789-000109-15
log 032406-15 - CI 2789-000089-15 and 2789-000001-16
log 032496-15 - CI 2789-000093-15
log 033197-15 - CI 2789-000094-15; 2789-000002-16 and 2789-000021-16
log 011043-15 - CI 2789-000045-15

Non-compliance identified during inspection 2016_226192_0013 related to LTCHA 2007, S.O. 2007, chapter 8, s.76 will be issued in this Critical Incident Report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Interim Director of Nursing, Associate Directors of Nursing, Director of Food Services, Food Services Supervisors, Environmental Services Manager, Office Manager, Registered Dietitian, Physiotherapist, Scheduling Clerk, Director of Resident Programs, Housekeeping and Laundry Supervisor, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Housekeepers, Pest Control Provider and residents.

Inspectors toured the home areas, observed the housekeeping and maintenance of the home, reviewed schedules, medical records, incident reports, maintenance logs, policy and procedure and program evaluations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **10 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure an analysis of every incident of abuse of a resident at the home was undertaken promptly after the licensee becomes aware of it, that annually an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences; that the results of the analysis were considered in the evaluation; that the changes and improvements under clause (b) were promptly implemented and that a written record of evaluation, changes and improvements, the date of the evaluation, the names of the persons who participate in the evaluation and the dates that the changes and improvements were implemented is prepared.

Record review on April 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2016, of critical incidents (CIS) 2789-000001-15, 2789-000008-15, 2789-000010-16, 2789-000011-16, 2789-000012-16, 2789-000028-15, 2789-000059-15, 2789-000047-15, 2789-000062-15, 2789-000094-15, 2789-000002-16 and 2789-000021-16 submitted to the Ministry of Health by the licensee, revealed that an analysis of every incident of abuse of a resident was not completed.

Interview with Associate Director of Care (ADOC) #101 on April 14, 2016, revealed there was no annual evaluation completed to determine the effectiveness of the licensee's policy under section 20 of the Act. The interview further confirmed there was no written record of an evaluation.

ADOC #101 confirmed it was the homes expectation that an annual evaluation be completed to determine the effectiveness of the licensee's policy under section 20 of the Act.

The licensee failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of them; that at least annually an evaluation of the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents was undertaken, considering the results of incident analysis and identifying changes and improvements to be implemented promptly. [s. 99.]

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program included an annual resident satisfaction evaluation of continence care products

in consultation with residents, substitute decision-makers and direct care staff.

Review of the continence care and bowel management program binder revealed there was no annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff for the year 2015.

Interview with the continence care and bowel management program lead #134 on April 11, 2016, confirmed there was no annual resident satisfaction evaluation of continence care products for 2015, and it was the homes expectation that an annual resident satisfaction evaluation of continence care products be completed. [s. 51. (1) 5.]

2. The licensee has failed to ensure that the resident who was incontinent received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review on April 11, 2016, for residents #026, #025 and #023 revealed they were to use incontinence products.

Interview with the Resident Assessment Instrument (RAI) Coordinators #124 and #125 on April 11, 2016, revealed the continence assessment should be captured in Point Click Care under the assessment tab, titled Bladder and Bowel Continence Assessment.

Record review of the assessments completed for residents #026, #025 and #023, revealed there were no completed assessments titled “Bladder and Bowel Continence”.

Interview with the Continence Care Program lead #134 on April 11, 2016, revealed the assessments for the continence program have not been completed to date and it was the homes expectation that residents who were incontinent received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

3. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

Record review on April 11, 2016, for residents #026, #025 and #023 revealed they used incontinence products.

Review of the resident's plans of care revealed there was a variant amount of information documented, but all of the residents #026, #025 and #023 had not received an assessment of continence.

Review of the Continence Program policy VII-D-10.10 on April 11, 2016, revealed residents should have an individualized program of continence in their plan of care which would include scheduled times for checking, changing and toileting residents, a specific toileting regimen for continent or potentially continent residents and specific product usage for incontinent resident as per the product manual.

Interview with the Continence Program Lead #134 on April 11, 2016, confirmed residents #026, #025 and #023 did not have individualized plans of care to promote and manage bowel and bladder continence based on assessment because assessments were not completed. [s. 51. (2) (b)]

4. The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to a person to toilet.

Interview with resident #025, revealed the resident was told by staff that provided care, to use the incontinence product to eliminate and the staff refused to put the resident on the toilet. During interview resident #025 identified they were experiencing symptoms potentially related to eliminating appropriately.

Interview with Personal Support Worker (PSW) #123 revealed resident #025 was not assisted to the toilet or a commode as they required use of a specified medical device. PSW #123 indicated that residents using specified medical devices were to use a continence product to eliminate their bladder and bowels and staff were to change the continence product.

Interviews with three Resident Assessment Instrument (RAI) Coordinators #107, #124 and #125, revealed when residents were designated as requiring a specified medical device, they were to use an incontinence pad which would be changed by staff.

Record review of resident #025's plan of care revealed: Toilet use, Resident #025

required total assistance from two staff for toilet use. Staff to change in bed.

A record review of the number of resident’s in the home who required use a specified medical device, revealed 13.7 percent of the home's population required us of the device.

Interview with the Physiotherapist (PT) #127 confirmed it was the staff’s practice to have residents who were designated to require the specified medical device, eliminate the bladder and bowels in a continence product and the continence product would be changed by staff. This came to PT #127's attention January 2016, and the PT explained this concern was forwarded to management.

An interview with Assistant Director of Care (ADOC) #101 confirmed that the residents who required a specified medical device were required to use incontinence products for elimination of their bladder and bowels.

A record review on April 8, 2016, of the internal investigation dated February 13, 2015, revealed the Personal Support Worker (PSW) being interviewed had identified residents that wear a “diaper” were to “go in the diaper”.

Interview with resident #026 confirmed the resident had been told to use their incontinence product instead of using the toilet by care givers.

Interview with the Interim Director of Care #102 on April 8, 2016, confirmed it was the homes expectation that continence care products should not be used as an alternative to providing assistance to a person to toilet. [s. 51. (2) (e)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring the resident who is incontinent receives an assessment that includes the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require and ensuring that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A record review of critical incident #2789-000001-15 revealed residents #021 reported an alleged abuse incident to their Substitute Decision Maker (SDM) on a specified date.

The Associate Director of Care (ADOC) #101 had completed an internal investigation and implemented an intervention in the plan of care that two staff would be present, for all aspects of resident #021's care, for the resident's safety.

A record review of resident #021's plan of care revealed the intervention of two staff to provide all aspects of care was put in place.

The intervention remained in place until the Resident Assessment Instrument Coordinator (RAI Coordinator) #107 removed the intervention from the plan of care in 2015, based on the staff coding the care provided for resident #021 as one staff member being present for the care provided.

An interview with Personal Support Worker (PSW) #103 on April 4, 2016, revealed the care provided for resident #021 was with one staff except for transfers then two staff would be present.

An interview with ADOC #101 on April 5, 2016, confirmed the care set out in the plan of care was not provided to resident #021 as specified in the plan of care and it was the homes expectation that the care set out in the plan of care should be provided to the resident as specified in the plan. [s. 6. (7)]

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

The plan of care for Resident #003 revealed that resident #003 was to a specified intervention by a Personal Support Worker (PSW).

On a specified date in 2015, resident #003 was involved in a resident to resident altercation.

Incident investigation notes and interview with the Associate Director of Care (ADOC) #141 confirmed that the PSW on duty on the specified date in 2015, had left at shift end and the PSW arriving for the subsequent shift was at the nurse's station receiving report when the incident occurred leaving resident #003 unattended. ADOC #141 further confirmed that the expectation would be that shift report for resident #003 should have been done at the bedside with both PSW's present.

The licensee failed to ensure that the specified intervention set out in the plan of care for resident #003 was provided as specified in the plan which resulted in a resident to resident altercation. [s. 6. (7)]

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

On December 28, 2015, resident #046 was observed by a Personal Support Worker to be adjusting their bed . The resident required the head of the bed to be elevated to forty five degrees at all times related to an identified risk.

Critical incident 2789-000045-15, identified that on a specified date resident #046 was found in bed, and the resident was in distress.

Interview with Associate Director of Care #141 confirmed that resident #046 had not been reassessed and the care plan reviewed and revised to address the increased risk associated with the resident being able to change the position of the bed independently.

The plan of care at the time of the incident included that staff were to maintain the head of the bed in an elevated position and signage over the bed indicated that the resident was to have the head of the bed elevated at all times.

Interview with ADOC #141 confirmed that interventions to ensure that the resident did not independently adjust the bed had not been included in the plan of care and offered that the control could have been locked out to ensure the residents safety.

The licensee failed to ensure that resident #046 was reassessed and the plan of care reviewed and revised when the resident was observed to be capable of adjusting the bed and increasing their risk. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of critical incident report #2789-000012-16 revealed resident #025 had reported physical and verbal abuse to the Assistant Director of Care (ADOC) #101.

Interview with resident #025 revealed some staff can be rough when providing care.

Observation of resident #025 revealed two area of altered skin integrity.

Review of the homes internal investigation, revealed Personal Support Worker (PSW) #123 was alleged to have abused the resident and had been off work pending investigation.

Review of the schedule revealed PSW #123 returned to work and was working with residents of the home following a one day suspension, without any re-education or review of the Prevention of Abuse policy.

Interview with PSW #123 revealed the PSW's opinion was that any issues with the resident were because of the resident.

Interview with ADOC #101 revealed the home believed the abuse had occurred.

Interview with Executive Director #100 confirmed the licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

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 received retraining annually related to the following; The Residents' Bill of Rights, Policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protection.

Interviews with Registered Nurse (RN) #104 and Registered Practical Nurse (RPN) #105 on April 4, 2016, revealed they were not aware of "Whistle-blowing protection". During the interview, RN #104 and RPN #105 explained it was not always possible for the staff to attend the mandatory education sessions.

Record review on April 5, 2016, revealed 21.18 percent of staff failed to complete 2015, Abuse & Neglect education provided by the home.

Interview with the Assistant Director of Care (ADOC) #101 on April 5, 2016, confirmed that 21.18 percent of the staff failed to complete the 2015, annual Abuse & Neglect education and it was the homes expectation that 100% of the staff receive retraining annually related to the Residents' Bill of Rights, the policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protections. [s. 76. (4)]

2. The licensee has failed to 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, annually: 1. Abuse recognition and prevention.

Critical Incident log #004576-15 reported an injury to resident #042 as a result of actions of a specified staff member.

Investigation into the incident conducted by the home identified that the injury sustained by the resident was caused by the staff member.

Review of the education provided to the staff member identified that they had not received training on the prevention of abuse between October 30, 2012, and June 15, 2015.

The licensee failed to ensure that a specified staff member received training on the prevention of abuse and neglect annually as required by O. Reg. 79/10 s. 221 (2)(1). [s. 76. (7) 1.]

3. The licensee has failed to ensure that all staff at the home that provide direct care to residents, as a condition of continuing to have contact with residents, received annual training on behavior management.

Course Status Records dated January 14, 2015 to December 31, 2015, revealed that the home’s training related to behaviour management was entitled "What is Dementia Canada" and "Communicating with Dementia for Canada".

Course Status Records further revealed that 64 of 197 (32%) of direct care staff had not completed the training "What is Dementia in 2015". Course status records revealed that 58 of 197 (29%) of direct care staff had not completed the training "Communicating with Dementia Canada".

Interview with Associate Director of Care #101 confirmed that all direct care staff had not completed the homes behaviour management training in 2015.

The licensee has failed to ensure that all direct care staff received the homes behavior management training annually. [s. 76. (7) 3.]

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 ensuring that all staff received retraining annually related to the following; The Residents' Bill of Rights; Policy to promote zero tolerance of abuse and neglect of residents; duty to make mandatory reports under section 24; whistle-blowing protection; behaviour management and abuse recognition and prevention, 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 there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's policy Abuse & Neglect – Zero Tolerance: Prevention of Resident Abuse, XV-A_10.80, page three of five, point 5) stated that the Executive Director/ Administrator interviews the resident, other residents, or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness is to take detailed notes of the conversation.

A) Record review on April 12, 2016, of Critical Incident #2789-000047-15 related to staff to resident abuse, revealed there were no investigation notes.

An interview with the Associate Director of Care (ADOC) #101 on April 12, 2016, confirmed there were no investigation notes available.

An interview with ADOC #101 confirmed there were no notes supporting the investigation and it was the homes expectation that a witness should take detailed notes of the conversations completed during the investigation of alleged abuse.

B) Record review on April 13, 2016, of Critical Incident #2789-000043-15 related to staff to resident abuse revealed there were no investigation notes.

An interview with the Assistant Director of Care (ADOC) #101 on April 13, 2016, confirmed there were no investigation notes present.

Notes were provided by the home, but failed to address the alleged abuse, failed to include interview of the resident, failed to include interview of staff working on that shift. There was insufficient documentation to conclude verbal abuse had not occurred.

An interview with ADOC #101 confirmed there were no notes supporting the investigation and it was the homes expectation that a witness should take detailed notes of the conversations completed during the alleged abuse investigation.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) 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:
1. 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. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was 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. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of the continence care and bowel management program binder revealed there was no evaluation, in accordance with evidence-based practices, of the continence care and bowel management program for the year 2015.

An interview with the continence care and bowel management lead #134 on April 11, 2016 confirmed there was no evaluation of the continence care and bowel management program for the year 2015, and it was the homes expectation that the program should be evaluated and updated at least annually in accordance with evidence-based practices. [s. 30. (1) 3.]

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. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation of the Responsive Behaviour Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Interview with Associate Director of Care (ADOC) #141 and record review of the homes Quality Management-LTC Program/Committee Evaluation Tool for Responsive Behaviours, for the period of October 2014 to October 2015, revealed that the evaluation date and the date that the changes were implemented were not included in the report. [s. 53. (3) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an an unexpected or sudden death, including a death resulting from an accident or suicide in the home.

Resident #046 was found in distress. The resident died suddenly before transfer to hospital.

Interview with Associate Director of Care #141 confirmed that the resident's death was unexpected. ADOC #141 confirmed that the incident report was not submitted to the Director immediately and that the after hours line had not been accessed to notify the Director of an unexpected death.

The licensee failed to ensure that Director was immediately informed, in as much detail as was possible in the circumstances, of an an unexpected or sudden death, including a death resulting from an accident or suicide in the home [s. 107. (1)]

2. The licensee has failed to ensure that the Director was informed in writing of an incident under subsection (3.1), within 10 days of becoming aware of the incident, setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

On April 10, 2015, resident #047 had an episode that required staff to initiate interventions. The interventions were ineffective in the residents current position and the resident was moved to the floor, emergency services were called and the resident transferred to hospital.

On return to the home resident #047 complained of pain. X-ray confirmed the resident

had sustained an injury.
The resident was transferred to hospital.

The Director was notified of the resident's transfer to hospital under section 3.1 via the after hours line. No written report was submitted to the Director as required within 10 days of becoming aware of the incident. A critical incident was submitted to the Director 23 days after the licensee was made aware of the transfer to hospital resulting in a significant change in the residents health.

Interview with Associate Director of Care #101 confirmed that the written report related to resident #047's transfer to hospital and significant change in condition was not submitted to the Director within 10 business days of becoming aware of the change.

The licensee failed to ensure that the Director was informed in writing of an incident under subsection (3.1), within 10 days of becoming aware of the incident. [s. 107. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) 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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training was provided related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

Record review of training records on April 11, 2016, revealed 35.7 percent of staff who provide direct care to residents had not completed the bowel and bladder care training for the year 2015.

Interview with the Continence Care and Bowel Management lead #134 on April 11, 2016 confirmed 35.7 percent of the staff who provide direct care to residents had not completed the 2015, Bowel and Bladder Care Training and it was the homes expectation that 100 percent of the staff who provide direct care to residents should have completed the 2015, Bowel and Bladder Care Training. [s. 221. (1) 3.]

Issued on this 27th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), ALISON FALKINGHAM (518), REBECCA DEWITTE (521), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_226192_0014
Log No. / Registre no:	007242-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 25, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sara Rooney

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:

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. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall ensure that analysis of every incident of abuse of a resident at the home is undertaken, and that annual evaluation of the effectiveness of the Prevention of Abuse Policy is completed.

Grounds / Motifs :

1. The licensee has failed to ensure an analysis of every incident of abuse of a resident at the home was undertaken promptly after the licensee becomes aware of it, that annually an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences; that the results of the analysis were considered in the evaluation; that the changes and improvements under clause (b) were promptly implemented and that a written record of evaluation, changes and improvements, the date of the evaluation, the names of the persons who

participate in the evaluation and the dates that the changes and improvements were implemented is prepared.

Record review on April 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2016, of critical incidents (CIS) 2789-000001-15, 2789-000008-15, 2789-000010-16, 2789-000011-16, 2789-000012-16, 2789-000028-15, 2789-000059-15, 2789-000047-15, 2789-000062-15, 2789-000094-15, 2789-000002-16 and 2789-000021-16 submitted to the Ministry of Health by the licensee, revealed that an analysis of every incident of abuse of a resident was not completed.

Interview with Associate Director of Care (ADOC) #101 on April 14, 2016, revealed there was no annual evaluation completed to determine the effectiveness of the licensee's policy under section 20 of the Act. The interview further confirmed there was no written record of an evaluation.

ADOC #101 confirmed it was the homes expectation that an annual evaluation be completed to determine the effectiveness of the licensee's policy under section 20 of the Act.

The licensee failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of therm; that at least annually an evaluation of the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents is undertaken, considering the results of incident analysis and identifying changes and improvements to be implemented promptly.

Recurrent incidents of alleged abuse involving the same residents and staff were identified to have a potential for actual harm. The scope was identified as a pattern within the incidents reviewed during the course of this inspection. There was no history of non-compliance related to legislation. (521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

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. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that residents #025, #026 and every other resident assessed to require use of a specified medical device has their continence reassessed using a clinically appropriate assessment instrument and where the resident is assessed to be potentially continent or continent some of the time, these residents receive support and assistance to become continent or continent some of the time, and ensuring that continence care products are not used as an alternative to providing assistance to a person to toilet.

Grounds / Motifs :

1. The licensee has failed to ensure that the continence care and bowel management program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

Review of the continence care and bowel management program binder revealed there was no annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff for the year 2015.

Interview with the continence care and bowel management program lead #134 on April 11, 2016, confirmed there was no annual resident satisfaction evaluation of continence care products for 2015, and it was the homes expectation that an annual resident satisfaction evaluation of continence care products be completed. [s. 51. (1) 5.]

2. The licensee has failed to ensure that the resident who was incontinent received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review on April 11, 2016, for residents #026, #025 and #023 revealed they were to use incontinence products.

Interview with the Resident Assessment Instrument (RAI) Coordinators #124 and #125 on April 11, 2016, revealed the continence assessment should be captured in Point Click Care under the assessment tab, titled Bladder and Bowel Continence Assessment.

Record review of the assessments completed for residents #026, #025 and #023, revealed there were no completed assessments titled "Bladder and Bowel Continence".

Interview with the Continence Care Program lead #134 on April 11, 2016, revealed the assessments for the continence program have not been completed to date and it was the homes expectation that residents who were incontinent received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

3. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

Record review on April 11, 2016, for residents #026, #025 and #023 revealed they used incontinence products.

Review of the resident's plans of care revealed there was a variant amount of information documented, but all of the residents #026, #025 and #023 had not received an assessment of continence.

Review of the Continence Program policy VII-D-10.10 on April 11, 2016, revealed residents should have an individualized program of continence in their plan of care which would include scheduled times for checking, changing and toileting residents, a specific toileting regimen for continent or potentially continent residents and specific product usage for incontinent resident as per the product manual.

Interview with the Continence Program Lead #134 on April 11, 2016, confirmed residents #026, #025 and #023 did not have individualized plans of care to promote and manage bowel and bladder continence based on assessment because assessments were not completed. [s. 51. (2) (b)]

4. The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to a person to toilet.

Interview with resident #025, revealed the resident was told by staff that

provided care, to use the incontinence product to eliminate and the staff refused to put the resident on the toilet. During interview resident #025 identified they were experiencing symptoms potentially related to eliminating appropriately.

Interview with Personal Support Worker (PSW) #123 revealed resident #025 was not assisted to the toilet or a commode as they required use of a specified medical device. PSW #123 indicated that residents using specified medical devices were to use a continence product to eliminate their bladder and bowels and staff were to change the continence product.

Interviews with three Resident Assessment Instrument (RAI) Coordinators #107, #124 and #125, revealed when residents were designated as requiring a specified medical device, they were to use an incontinence pad which would be changed by staff.

Record review of resident #025's plan of care revealed: Toilet use, Resident #025 required total assistance from two staff for toilet use. Staff to change in bed.

A record review of the number of resident's in the home who required use a specified medical device, revealed 13.7 percent of the home's population required us of the device.

Interview with the Physiotherapist (PT) #127 confirmed it was the staff's practice to have residents who were designated to require the specified medical device, eliminate the bladder and bowels in a continence product and the continence product would be changed by staff. This came to PT #127's attention January 2016, and the PT explained this concern was forwarded to management.

An interview with Assistant Director of Care (ADOC) #101 confirmed that the residents who required a specified medical device were required to use incontinence products for elimination of their bladder and bowels.

A record review on April 8, 2016, of the internal investigation dated February 13, 2015, revealed the Personal Support Worker (PSW) being interviewed had identified residents that wear a "diaper" were to "go in the diaper".

Interview with resident #026 confirmed the resident had been told to use their incontinence product instead of using the toilet by care givers.

Interview with the Interim Director of Care #102 on April 8, 2016, confirmed it was the homes expectation that continence care products should not be used as an alternative to providing assistance to a person to toilet.

Severity was identified to be minimal harm or potential for actual harm in that residents expressed physical and emotional responses in relation to not being assisted with toileting. Scope was widespread as 100 percent of residents whose mobility was limited and used a specified medical device were required to eliminate in their continence product. There was no history of non-compliance identified in relation to this legislation. (521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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