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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Oct 4, 2019	2019_671684_0032	033158-18, 001040-19, 001196-19, 004241-19, 004327-19, 004568-19, 005287-19, 007527-19, 015393-19, 015882-19	Complaint

Licensee/Titulaire de permis

Unionville Home Society
4300 Highway #7 MARKHAM ON L3R 1L8

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

Union Villa
4300 Highway #7 Unionville ON L3R 1L8

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

SHELLEY MURPHY (684), AMANDA BELANGER (736), SHANNON RUSSELL (692), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 16-20 and September 23-27, 2019.

The following intakes were inspected upon during this Complaint Inspection:
-One complaint related to fall prevention;
-One complaint related nutrition and housekeeping;
-One complaint related to food quality;
-One complaint related to skin and wound care and pain management;
-One complaint related to infection prevention and control and plan of care;
-One complaint related to continence care;
-One complaint related to reporting complaints to the Director, and;
-Two complaints related to staffing.

Follow Up inspection #2019_671684_0034 and Critical Incident System inspection #2019_671684_0033 were conducted concurrently with this Complaint inspection.

PLEASE NOTE: Non-compliance of a Voluntary Plan of Correction (VPC) related to s. 20 of the LTCHA 2007, were identified in a concurrent inspection, #2019_671684_0033, and were issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Acting Administrator, Director of Care (DOC), Registered Dietitian (RD), Social Worker (SW), Manager of Recreation, Facility and Environmental Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator, Cook, Dietary Aide, Activity Aide, residents and families.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 was reassessed at least weekly by a member of the registered nursing staff.

A Complaint was submitted to the Director, which alleged that resident #016's skin and wound care was not provided regularly.

Inspector #684 reviewed the care plan for resident #016 which provided specific instructions for skin and wound care.

During a review of the progress notes for resident #016, Inspector #684 identified that wound care interventions were not completed as assigned.

Inspector #684 reviewed a binder named "Clinical resource Guide for Skin and Wound Care", and identified a document which stated “Weekly skin assessment: Document in PCC, do not just check mark".

During a interview with Registered Practical Nurse (RPN) #101, they stated that the “Expectation was that PCC Skin and Wound assessments be completed with weekly wound assessments”. Inspector #684 reviewed the PCC documentation with RPN #101,

and they confirmed that the wound interventions were missing.

Inspector #684 and the Director of Care (DOC) reviewed the Point Click Care progress notes for resident #016, the DOC confirmed they were missing skin and wound interventions. The DOC stated "Every week there should be a description of the wound, treatment plan if working, if nutrition support is needed, if they need to send a referral if it is getting worse or they need a different type of dressing, that is the reason for doing weekly assessments". [s. 50. (2) (b) (iv)]

2. A complaint was submitted to the Director, indicating that the wound care program had been an issue in the home. The complainant indicated that resident #013 had altered skin integrity to a specified area on their body and their altered skin integrity was not being properly cared for and it was worsening.

Inspector #692 reviewed resident #013's progress notes in PCC for the skin and wound for a specified period of time. Inspector #692 identified that wound care interventions were not completed five times during the specified period of time.

In an interview with RPN #114, they identified that resident #013 had an acquired area of altered skin integrity. RPN #114 indicated that registered staff were to complete an intervention for the resident's altered skin integrity for a specified period of time; and the intervention was to be documented in PCC. RPN #114 indicated that if there was not a intervention note completed in PCC then the intervention was not completed.

In an interview with Registered Nurse (RN) #105, who was also the wound care lead for the home, they stated that their expectation from the registered staff members was that they were to complete specified altered skin integrity interventions when an area of altered skin integrity was identified, and then altered skin integrity interventions were to be completed as specified. RN #105 reviewed resident #013's altered skin integrity intervention notes in PCC and confirmed that there were five weekly altered skin integrity notes not completed for the specified period of time. RN #105 identified that resident #013's area of altered skin integrity had worsened, which was why it was important to monitor and assess the area of altered skin integrity frequently to prevent the it from worsening, and promote healing.

Inspector #692 interviewed the DOC, who confirmed there were five missing PCC interventions for altered skin integrity for resident #013, and they should have been completed. [s. 50. (2) (b) (iv)]

3. A complaint was submitted to the Director, indicating that the wound care program was an issue in the home. The complainant indicated that resident #015 had altered skin integrity, and that they were concerned that the altered skin integrity was not being properly cared for.

Inspector #692 reviewed resident #015’s progress notes in PCC for the altered skin integrity for a specified period of time in 2019. Inspector #692 identified that a wound care intervention was not completed four times during the specified time frame.

In an interview with RPN #101, they identified that resident #015 had acquired an area of altered skin integrity. RPN #101 indicated that registered staff were to complete an intervention for the resident’s wound for a specified amount of time; and the assessment was to be documented in the skin and wound assessment note in PCC. RPN #101 indicated that if there was not a skin and wound intervention note completed in PCC then the interventions was not completed.

In an interview with RN #105, they reviewed resident #015’s notes and confirmed that there were four interventions that had not been completed during the specified time.

Inspector #692 interviewed the DOC, confirmed there were four missing altered skin integrity interventions for the specified time frame for resident #015, and they should have been completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A complaint was submitted to the Director, related to not having a registered nurse (RN) in the home.

Inspector #744 reviewed the home's staffing plan, which indicated there was to be one RN on the day, evening and night shift.

The Daily Roster Report was reviewed for a specified day which indicated that evening and night shifts were filled by agency RNs.
The report was reviewed for two other specified days which also indicated that evening shift was filled by agency RNs.

Inspector #744 interviewed the DOC and asked why the RN shifts were being filled by agency RN staff. DOC stated "I pre-schedule because I try to help the staffing nurse. I pre-booked all the agency RNs for [a specified month]". [s. 8. (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 to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director, regarding an allegation of staff to resident abuse. The CIS report identified that resident #009 had reported to RPN #114 an incident that involved PSW #107. The CIS report further identified that PSW #107 had not provided the assistance with care that resident #009 required.

Emotional abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident".

Inspector #692 reviewed the home’s internal investigation notes, which identified that there had been video footage obtained from the date and time of the reported incident. The video footage identified that PSW #107 had responded to resident #009 when they required care. When PSW #107 responded, they did not provide the necessary care that resident #009 required. The internal investigation notes identified a letter addressed to PSW #107, which identified that the allegation of resident abuse was founded, and that PSW #107 was issued disciplinary action in relation to the incident.

A review of the home’s policy titled, “Zero Tolerance of Abuse and Neglect”, #16505, last reviewed October 18, 2018, indicated that there was zero tolerance of abuse or neglect of the residents, and that the policy applied to all staff of the home.

Inspector #692 interviewed the DOC, who identified that through the investigation and a review of the video footage, that PSW #107 had been abusive in their actions towards

resident #009 and had not complied with the home’s zero tolerance of abuse policy. [s. 20.]

2. A complaint was submitted to the Director related to resident #001. The complaint indicated that the resident was not provided with two meals, and that the resident had not received any care until a specified time on a specific day.

O. Reg 70/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of interaction that jeopardizes the health, safety, or well-being of one or more residents.

In an interview with the DOC, they indicated to the Inspector that based on the investigation, the resident was not provided with care as set out in their plan of care, and was therefore neglected. The DOC indicated that the PSW did not comply with the zero tolerance of abuse policy, and should have.

In an interview with the Administrator, they indicated to the Inspector that based on the home’s investigation of the allegation of neglect towards resident #001, the PSW staff assigned to the resident did not provide the resident the necessary care they required on a specified day. The Administrator also indicated that the resident's plan of care directed staff to provide frequent checks on the resident. The Administrator confirmed that based on the investigation, the staff did not comply with the home’s zero tolerance of abuse policy related to resident #001, and should have. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of resident, and shall ensuring that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed using a clinically appropriate post fall assessment tool.

A complaint was submitted to the Director regarding resident #001. The complainant indicated that the resident had had a number of falls and there was concern regarding their fall prevention interventions.

Inspector #736 reviewed the progress notes for resident #001 and noted an entry, that indicated that the resident had fallen and sustained an injury. The Inspector was unable to locate any post fall assessment using the clinically appropriate post fall assessment tool from the home.

In an interview with RPN #101, they indicated to Inspector #736 that after a resident has sustained a fall, the Registered Staff were to complete a post fall assessment on PCC under the risk management tab. Together, the RPN and the Inspector reviewed resident #001’s progress notes and were unable to locate a post fall assessment. RPN #101 indicated to the Inspector that based on the progress notes for resident #001, there should have been a post fall assessment completed.

In an interview with the DOC, they indicated to Inspector #736 that after a resident has had a fall, the resident was to be assessed using the post fall assessment tool located in PCC, under risk management. The DOC indicated that based on the progress notes for resident #001, they had a fall and no post fall assessment was completed, however, it should have been. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system to measure and record each resident’s weight monthly.

A complaint was submitted to the Director related to resident #001 and changes in weights.

Inspector #736 reviewed the weights for resident #001 from admission to time of the inspection. The Inspector noted that the resident had not been weighed each month in 2019.

In separate interviews with PSW #102 and RPN #101, they indicated to Inspector #736, that every resident was weighed on a monthly basis, and it was documented in PCC, under the weights and vitals tab.

Together, RPN#101 and the Inspector reviewed resident #001’s weights and vitals tab in PCC. The RPN confirmed that resident #001 had not been weighed in a specified month and should have been.

In an interview with the DOC, they indicated to the Inspector that all residents were to be weighed on a monthly basis, and the weights were to be recorded in PCC under the weights and vitals tab. Together, the DOC and Inspector reviewed the weights and vitals tab for resident #001, and the DOC indicated that resident #001 did not have their weight recorded in a specified month in 2019. The DOC reviewed the progress notes for resident #001 and was unable to locate any notes to indicate why the resident had not been weighed. The DOC indicated that the resident should have been weighed. [s. 68. (2) (e) (i)]

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 for a weight monitoring system to measure and record with respect to each resident weight on admission and monthly thereafter, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director related to resident #001 related to weight loss.

Inspector #736 reviewed the resident's progress noted and identified an entry that there had been a recommendation to trial a specified medication. The progress note also indicated that the resident's Substitute Decision Maker (SDM) had agreed to the trial.

Inspector #736 reviewed the physician's orders sheet, and noted that the Physician gave a telephone order to have resident #001 receive the medication as ordered.

A further review of the progress notes for resident #001, indicated that it was discovered that the resident had not received their scheduled medication four times as ordered.

In an interview with RPN #101, they indicated to Inspector #736, that resident #001 had been ordered a specified medication. The RPN further indicated that they were aware of the medication error that took place, and that the resident had not received the scheduled medication four times.

In an interview with the DOC, they indicated to Inspector #736 that they were aware of the medication error for resident #001. The DOC indicated to the Inspector that the medication was not given to resident #001 four times as per the prescriber's direction. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 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 provide direct care to the resident.

A complaint was submitted to the Director related to improper care of resident #004 concerning continence care.

The Inspector reviewed resident #004's health care record and identified that the resident had a physician's order for a specific continence care intervention which was to be completed in a specified time frame.

Inspector #744 further reviewed resident #004's health care records and identified that the resident had an intervention for continence care with a specified time frame.

In an interview with RPN #109, they stated that the nurse practitioner had told them to amend the physician's order to have the continence care intervention time frame adjusted. They further stated that they should have amended all of resident #004's health care records to reflect the change in the physician's order.

Inspector #744 interviewed the DOC who indicated that the continence intervention was unclear in resident #004's health care records, and that clear direction of interventions was needed for resident safety. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was documented.

A complaint was submitted to the Director related to the care provided to resident #001. The complaint indicated that the resident did not receive their dietary interventions or care as required on a specified date in 2019.

Inspector #736 reviewed the clinical records for resident #001, and noted that a specific intervention was not signed for 36 times in a specified month.

In an interview with RN #108, they indicated to the Inspector that staff would document the care provided on Point of Care (POC). Together, the RN and Inspector reviewed the POC for resident #001 for the specified month, and the RN indicated that all the sections should have been completed. The RN further indicated to the Inspector that because of the blanks, care was not documented as provided.

In an interview with the DOC, they indicated to the Inspector that staff documented care provided on POC. The DOC confirmed that there were blanks on the POC report. The

DOC indicated to the Inspector that the care set out in the plan of care was not documented related to resident #001's specified intervention, and it should have been. [s. 6. (9) 1.]

3. A complaint was submitted to the Director, related to shortage of staff and lack of personal care for resident #003.

Inspector #744 reviewed resident #003's health care records and identified that no care was documented for a specified time frame for the resident.

In an interview with PSW #117, they stated that all care was provided for resident #003 on the identified day in 2019. They further stated that the home was short staffed on that day in 2019, and that they doubt that the agency staff completed all the documentation that day.

Inspector #744 interviewed the DOC who confirmed that documentation of resident #003 was not completed on the specified day, and that all care must be documented in the resident's health care record. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A complaint was submitted to the Director, indicating concerns with the care provided to resident #011 when they were exhibiting a change in their condition.

Inspector #692 reviewed resident #011's health care records, identifying a progress note, which indicated an intervention that was put in place to ensure the resident's safety.

Inspector #692 reviewed resident #011's care plan and was unable to locate a focus that indicated the safety interventions that was put in place for resident #011.

In an interview with resident #011, they identified the safety intervention that was implemented for them.

Inspector #692 interviewed PSW #125, who indicated that they were to review the residents care plan in order to know what care needs the resident required. PSW #125 identified that the home had implemented an intervention to ensure resident safety.

In separate interviews with RPN #114 and RN #108, they identified to Inspector #692 that staff were to review the residents care plan in order to know what care was to be provided, and it was to be updated with the current needs of the resident. RN #108 recalled that the safety intervention that was in place for resident #011. RN #108 confirmed that they had not revised resident #011's care plan when the safety intervention was changed.

During an interview with Inspector #692, the DOC identified that resident #011 had an intervention put in place to ensure their safety. The DOC confirmed that resident #011's care plan had not been revised to identify that staff were to complete specific interventions to ensure their safety, and it should have been. [s. 6. (10) (b)]

5. A complaint was submitted to the Director indicating concerns with the home's Infection Prevention and Control program, specifically isolation precaution and personal protective equipment (PPE) practices.

Inspector #692 reviewed a current Medical Diagnoses report from PCC, identifying that resident #016 had a Infectious diagnosis.

Inspector #692 reviewed resident #016's paper chart, identifying a laboratory report from a specific date, indicating that the resident had been identified as being positive for a infectious disease. A further review of a laboratory report from a later date indicated that resident #016 had been identified as being negative for the infectious disease.

Inspector #692 reviewed resident #016's care plan, at the time of the inspection, and identified a Infectious disease focus. Staff were to apply contact precautions for all personal care, which had been initiated on a specific date.

Together, RPN #101 and Inspector #692 reviewed resident #016's laboratory reports and their current care plan, in which RPN #101 confirmed that resident #016's care plan had not been revised to reflect that they had not been positive for a Infectious disease.

During an interview with Inspector #692, the Director of Care (DOC) indicated that a resident's care plan was to be updated continuously to ensure that it included current status and needs. They identified that resident #016's care plan had not been revised to identify that they were no longer positive for a Infectious disease, and that it should have been. [s. 6. (10) (b)]

6. A complaint was submitted to the Director, indicating concerns with the home's Infection Prevention and Control program, specifically isolation precaution and personal protective equipment (PPE) practices.

Inspector #692 reviewed a current Medical Diagnoses report from PCC, identifying that resident #017 had a Infectious disease diagnosis.

Inspector #692 reviewed resident #017’s paper chart, identifying a laboratory report, from a specific date, indicating that the resident had been identified as being positive for a Infectious disease. A review of the resident's health care records identified that the Infectious disease diagnosis had no longer been active as of a specified date.

Inspector #692 reviewed resident #017’s care plan, at the time of the inspection, and identified a focus for an Infectious disease and need for monitoring related to the Infectious disease. Staff were to apply contact precautions for all personal care.

Together, RPN#101 and Inspector #692 reviewed resident #017’s laboratory reports and their current care plan, in which RPN #101 confirmed that resident #017’s care plan had not been revised to reflect that they were no longer positive for the Infectious disease.

During an interview with Inspector #692, the Director of Care (DOC) indicated that a resident’s care plan was to be updated continuously to ensure that it included current status and needs. They identified that resident #017’s care plan had not been revised to identify that they were no longer positive for the Infectious disease and that it should have been. [s. 6. (10) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaint received concerning the care of a resident, or the operation of the home was immediately forwarded to the Director.

A complaint was submitted to the Director related to the care and services provided to resident #001. The complainant indicated that an email had been sent to the Chief Executive Officer (CEO) on a specified date in 2019, regarding care concerns for the resident.

Inspector #736 received a copy of the email complaint that was received by the home, which indicated that the complainant had concerns regarding the care of resident #001, as well as two other specific resident care areas.

The Inspector reviewed the home's internal complaints binder, and located a record of the complaint, which indicated that the CEO received the email complaint related to resident #001.

In an interview with the CEO, they indicated to the Inspector that they received an email complaint related to resident #001. The CEO indicated to the Inspector that any written complaint that was to be forwarded to the Director, would have been completed by the DOC. The CEO indicated that they were not aware of that an email was considered to be a written complaint, that would be forwarded to the Director.

In an interview with the DOC, they indicated to the Inspector that they were aware of the complaint that was submitted, related to the care of resident #001. The DOC indicated that the home did investigate the complaint and followed up with the complainant, however, the DOC was unaware of the requirement to forward written complaints to the Director.

In an interview with the Administrator, they indicated that any written complaint that required forwarding to the Director, would be completed by the DOC. The Administrator further indicated that they were aware of the email complaint that was received by the CEO on the specified date in 2019, related to the care of resident #001, however, it was not forwarded to the Director, as the home's policy indicated that only written complaint letters and faxes were accepted as written complaints. The Administrator also indicated that they were aware of the memo from the Director on a specified date in 2018, however

they were not aware that email complaints were considered to be written complaints to be forwarded to the Director. [s. 22. (1)]

2. A complaint was submitted to the Director, related to improper care of resident #004. The complainant had submitted a written complaint concerning care of resident #004 to Social Worker (SW) #106. The complaint stated that a continence care was performed poorly by RPN #101, which caused resident #004 to have a change in condition.

Inspector #744 reviewed the home’s policy titled, "Reporting Concerns and Complaints", with a revised date of June 25, 2017, which stated the "MOHLTC will be notified of verbal complaints that cannot be resolved in a timely manner and will be notified of any written compliant by the Administrator or designate".

Inspector #744 reviewed the Ministry of Health and Long Term Care (MOHLTC) reporting system used for reporting Critical Incidents (CIs) and was unable to locate the written complaint that was submitted to the home.

During an interview with SW #106, they stated that a written complaint regarding resident #004’s care was given to them on a specified date in 2019. SW #106 had immediately forwarded the written complaint and complaint form to the DOC.

In an interview with the DOC, they stated that they were not aware that the written complaint needed to be submitted to the Director when a Critical Incident (CI) report was submitted. [s. 22. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect had occurred, was immediately reported to the Director.

A complaint was submitted to the Director related to care provided to resident #001. The complaint contained an email from a date in 2019, that was addressed to the DOC, that indicated that it was noted that resident #001 was in their room for a specified period of time and had not been provided any care or certain dietary interventions.

Inspector #736 reviewed the reports submitted by the home related to allegations of neglect towards residents, and was unable to locate a CI report related to resident #001 and the allegation of neglect that was brought forward.

A review of the policy titled Zero Tolerance of Abuse and Neglect,#16505, last reviewed October 18, 2018, indicated that when a manager/designate receives a report of suspected or alleged, or actual incident of abuse or neglect, they would immediately report to the MOHLTC Director. The report was to be submitted by using the Critical Incident System form, under the Mandatory Report Section.

In an interview with the DOC, they indicated to the Inspector that they first became aware of the allegation of neglect for resident #001. The DOC further indicated that the allegation had not yet been submitted to the Director, however, the DOC was aware of the requirement to submit allegations of neglect to the Director immediately.

In an interview with Inspector #736, the Administrator indicated that they were aware of the requirement to immediately report all allegations of resident abuse or neglect to the Director through the CIS portal. The Administrator further indicated that it was the DOC’s responsibility to complete the CIS reports for resident abuse and neglect. The Administrator confirmed that they were aware of the allegation of neglect related to resident #001. Together, the Administrator and Inspector reviewed the CI reports submitted to the Director, and were unable to locate any report related to the allegation of neglect towards resident #001. The Administrator indicated to the Inspector that the allegation should have been reported to the Director as soon as the home became aware, and that they would immediately follow up with the DOC. [s. 24. (1)]

WN #10: 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 has failed to ensure that in respect to each of the interdisciplinary programs required under section 48 of this regulation, the program must have been evaluated and updated at least annually, and a written record kept 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 those changes were implemented.

Inspector #692 requested the program evaluation for the Skin and Wound Care program, and was not provided with any documentation indicating that the annual evaluation had been completed in 2018, as well as to date in 2019.

In an interview with the Director of Care (DOC), they indicated to Inspector #692, that the nursing, along with the multidisciplinary team were responsible to complete the annual program evaluation for the Skin and Wound Care program. The DOC indicated that the written review of the annual evaluation was to include the names of those who participated in the evaluation, the date of the evaluation, a summary of changes made, and the dates those changes were implemented.

The DOC indicated to the Inspector that the annual evaluation for the Skin and Wound Care program had not been completed annually, and it should have been. [s. 30. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written record of each annual evaluation of the staffing plan including 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.

A complaint was submitted to the Director, related to not having a registered nurse (RN) in the home.

Inspector #744 interviewed the Administrator and requested the last year’s annual evaluation of the staffing plan. They stated that last year’s evaluation could not be located. [s. 31. (4)]

Issued on this 10th day of October, 2019

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) : SHELLEY MURPHY (684), AMANDA BELANGER (736), SHANNON RUSSELL (692), STEVEN NACCARATO (744)

Inspection No. / No de l'inspection : 2019_671684_0032

Log No. / No de registre : 033158-18, 001040-19, 001196-19, 004241-19, 004327-19, 004568-19, 005287-19, 007527-19, 015393-19, 015882-19

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Oct 4, 2019

Licensee / Titulaire de permis : Unionville Home Society
4300 Highway #7, MARKHAM, ON, L3R-1L8

LTC Home / Foyer de SLD : Union Villa
4300 Highway #7, Unionville, ON, L3R-1L8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Julie Horne

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

To Unionville Home Society, 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. 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 section 50 (2) of the Ontario Regulations (O.Reg.) 79/10.

Specifically, the licensee must:
a) Ensure that residents #016, #015 and #013, and all other residents with altered skin integrity have weekly skin assessments completed and documented;
b) Re-educated all registered staff on weekly skin assessments and documentation requirements;
c) Create an Auditing System to ensure that required tasks are completed for every resident exhibiting altered skin integrity, and;
d) Maintain records for re-training, including who received the training, when it occurred, and what the content of the training included.

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 was reassessed at least weekly by a member of the registered nursing staff.

A Complaint was submitted to the Director, which alleged that resident #016's skin and wound care was not provided regularly.

Inspector #684 reviewed the care plan for resident #016 which provided specific instructions for skin and wound care.

During a review of the progress notes for resident #016, Inspector #684 identified that wound care interventions were not completed as assigned.

Inspector #684 reviewed a binder named "Clinical resource Guide for Skin and Wound Care", and identified a document which stated "Weekly skin assessment: Document in PCC, do not just check mark".

During a interview with Registered Practical Nurse (RPN) #101, they stated that the "Expectation was that PCC Skin and Wound assessments be completed with weekly wound assessments". Inspector #684 reviewed the PCC documentation with RPN #101, and they confirmed that the wound interventions were missing.

Inspector #684 and the Director of Care (DOC) reviewed the Point Click Care progress notes for resident #016, the DOC confirmed they were missing skin and wound interventions. The DOC stated “Every week there should be a description of the wound, treatment plan if working, if nutrition support is needed, if they need to send a referral if it is getting worse or they need a different type of dressing, that is the reason for doing weekly assessments”. [s. 50. (2) (b) (iv)]

(684)

2. A complaint was submitted to the Director, indicating that the wound care program had been an issue in the home. The complainant indicated that resident #013 had altered skin integrity to a specified area on their body and their altered skin integrity was not being properly cared for and it was worsening.

Inspector #692 reviewed resident #013’s progress notes in PCC for the skin and wound for a specified period of time. Inspector #692 identified that wound care interventions were not completed five times during the specified period of time.

In an interview with RPN #114, they identified that resident #013 had an acquired area of altered skin integrity. RPN #114 indicated that registered staff were to complete an intervention for the resident’s altered skin integrity for a specified period of time; and the intervention was to be documented in PCC. RPN #114 indicated that if there was not a intervention note completed in PCC then the intervention was not completed.

In an interview with Registered Nurse (RN) #105, who was also the wound care lead for the home, they stated that their expectation from the registered staff members was that they were to complete specified altered skin integrity interventions when an area of altered skin integrity was identified, and then altered skin integrity interventions were to be completed as specified. RN #105 reviewed resident #013’s altered skin integrity intervention notes in PCC and confirmed that there were five weekly altered skin integrity notes not completed for the specified period of time. RN #105 identified that resident #013’s area of altered skin integrity had worsened, which was why it was important to monitor and assess the area of altered skin integrity frequently to prevent the it from

worsening, and promote healing.

Inspector #692 interviewed the DOC, who confirmed there were five missing PCC interventions for altered skin integrity for resident #013, and they should have been completed. [s. 50. (2) (b) (iv)]

(692)

3. A complaint was submitted to the Director, indicating that the wound care program was an issue in the home. The complainant indicated that resident #015 had altered skin integrity, and that they were concerned that the altered skin integrity was not being properly cared for.

Inspector #692 reviewed resident #015's progress notes in PCC for the altered skin integrity for a specified period of time in 2019. Inspector #692 identified that a wound care intervention was not completed four times during the specified time frame.

In an interview with RPN #101, they identified that resident #015 had acquired an area of altered skin integrity. RPN #101 indicated that registered staff were to complete an intervention for the resident's wound for a specified amount of time; and the assessment was to be documented in the skin and wound assessment note in PCC. RPN #101 indicated that if there was not a skin and wound intervention note completed in PCC then the interventions was not completed.

In an interview with RN #105, they reviewed resident #015's notes and confirmed that there were four interventions that had not been completed during the specified time.

Inspector #692 interviewed the DOC, confirmed there were four missing altered skin integrity interventions for the specified time frame for resident #015, and they should have been completed. [s. 50. (2) (b) (iv)]

The severity of the issue was determined to be a level three, as there was actual harm to resident #013, which resulted in the wound worsening. The scope of the issue was level three, as it was related to three of the residents reviewed. The home had a level three compliance history, as they had ongoing non-

compliance with this section of the Ontario Regulation 79/10 which included:

-one voluntary plan of correction issued December 1, 2017, during a Resident Quality Inspection
(inspection #2017_650565_0016).
(692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 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 4th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shelley Murphy

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