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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_644507_0016	025027-17, 025087-17	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

STELLA NG (507)

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): November 1, 2, 6, 7, 8 & 9, 2017.

During the course of the inspection, the inspector(s) spoke with the administrator, interim director of care (IDOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), physiotherapists (PT), physiotherapy aide (PTA), environmental services manager (ESM), laundry aide (LA), and substitute decision maker.

During the course of the inspection, the inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staff education records, employee files, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **4 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 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 protect resident #001 from abuse and neglect from staff.

A) On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the braden scale for predicting pressure sore risk assessment dated two days after the admission, completed by staff #105 revealed that resident #001 had potential problem in regards to altered skin integrity.

Review of resident #001's electronic medication administration record (eMAR) for the above mentioned month, and physician's order revealed the resident was prescribed an identified medication at a specified dosage, frequency and route. The eMAR also revealed resident #001 had taken the identified medication for two days after admission.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

Review of an identified critical incident system report (CIS) submitted to the Ministry by the home on an identified date revealed staff #100 discovered and reported to the registered staff that resident #001 had an altered skin integrity on an identified date. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on the above mentioned identified date, staff #100 called staff #102 and showed staff #102 resident #001's altered skin integrity of a specified measurement.

B) In an interview, staff #105 stated that resident #001's written plan of care in regards to

transfer was revised two days after the admission due to the resident's physical and medical status.

In an interview, staff #100 stated that on the identified date, during meal service, resident #001 was observed not eating, and the resident stated he/she was not feeling well. Staff #100 then transported resident #001 from the dining room to the resident's room after meal service with the mobility device. Staff #100 placed the mobility device at a 90 degrees angle to the toilet by the sink, asked the resident to hold onto the grab bar on the wall on the right side of the toilet to stand up. Then staff #100 assisted the resident to sit down on the toilet. The mobility device was left in the doorway of the washroom. While the resident was sitting on the toilet, staff #100 remained in the washroom and called for assistance in fetching clean clothes and continent care product for the resident. Staff #101 arrived and handed the clean clothes and continent care product to staff #100. When resident #001 finished voiding in the toilet, staff #100 provided peri-care and assisted resident #001 to put the clean continent care product and clothes on, and asked the resident to stand up by holding onto the grab bar, then staff #100 assisted the resident to sit on the mobility device while staff #101 stood behind the mobility device at the doorway of the washroom. Staff #101 then placed the mobility device at the right side of the bed at a 45 degrees angle. Staff #100 asked the resident to stand up by holding onto the right side rail (a quarter length side rail was positioned at a vertical position at that time). Once the resident was standing, staff #101 moved the mobility device to the end of the bed. Staff #100 assisted resident #001 from the resident's left side and the resident turned anti clockwise, then sat down on the bed. Staff #101 left the room when resident #001 was sitting on the edge of the bed. Staff #100 elevated the head of the bed and put both the resident's legs onto the bed, then left the room.
Approximately an hour later, staff #100 did his/her round and observed #001 had altered skin integrity. Staff #100 reported to staff #102.

In an interview, staff #102 stated that on the identified date, he/she was called by staff #100 to resident #001's room. When arrived, staff #102 saw resident #001's altered skin integrity and asked staff #100 what happened, and staff #100 responded he/she did not know what happened. Staff #102 then went to the nursing station and asked staff #106 to measure and cover resident #001's altered skin integrity. Staff #102 then called for the ambulance and left a voice message for resident #001's family.

In an interview, staff #106 stated that on the identified date, he/she was told by staff #102 that resident #001 had an altered skin integrity and asked him/her to measure and cover the affected area. Staff #106 gathered some dressing supplies and went to another unit

on the first floor for a paper measuring tape as there was none on the unit. When staff #106 returned to the unit and arrived at resident #001's room, he/she saw an altered skin integrity. Staff #106 further described the altered skin integrity and stated it was so bad that he/she could not look at it to measure. Staff #106 then left resident #001's room and went to the nursing station, used the phone to call the facility charge nurse to arrive at resident #001's room.

In an interview, staff #107 stated that on the identified date, staff #106 called and asked him/her to arrive at resident #001's room. When staff #107 arrived, staff #100, #101, and #106 were in the room, staff #106 gave him/her the paper measuring tape and asked him/her to measure resident #001's altered skin integrity. Staff #107 measured the affected area and told staff #106 the measurement. Staff #107 covered the affected area with dressing.

C) In interviews, staff #100, #101, #102, #106 and #107 denied any knowledge of what happened to resident #001 that caused the injury from the time the resident left the dining room to when the altered skin integrity was discovered.

In an interview, staff #100 denied any falls or injuries resident #001 experienced during transfers on the identified date.

On an identified date, with the assistance of staff #100 and #101, the inspector re-enacted resident #001's transfer that took place on the above mentioned identified date in resident #001's room with the same bed. The inspector was standing by the right side of the bed and holding onto the side rail on the right side of bed. When the inspector turned anti clockwise so that the inspector could sit on the edge of the bed, the inspector's outer right knee was pressed against the knob and the edge of a flat metal connecting the knob and the bars of the side rail. The inspector observed the edges of the flat metal were not smooth. Staff #100 acknowledged resident #001's care plan indicated the resident required extensive assistance for transfer, and he/she transferred resident #001 without assistance of another staff member on the identified date.

In an interview, staff #102 stated that on the identified date, when he/she was called to resident #001's room and discovered the injury, he/she did not assess the resident, nor use the call bell to request assistance from other staff. Instead, staff #102 left the resident who had an injury, went to the nursing station and asked the staff #106 to measure and cover the affected area.

In an interview, staff #106 stated that on the identified date, he/she was asked by staff #102 to measure and cover resident #001's altered skin integrity. When he/she arrived at resident #001's room and saw the injury, he/she did not measure and cover the affected area nor assess the resident. Instead, staff #106 left the resident who had an injury, went to the nursing station and used the phone to call the facility charge nurse to arrive at the resident's room. Staff #106 also stated when he/she returned, he/she asked the resident was he/she OK, the resident opened his/her eyes, said something then closed his/her eyes. Staff #106 stated he/she was not able to hear what resident #001 said, but he/she did not further assess the resident.

In an interview, staff #111 stated two days after the above mentioned incident, the management team became aware of the incident involving resident #001 who was found with an injury of altered skin integrity two days prior. The home initiated the investigation and notified the police and the Ministry. Staff #111 further stated that during the beginning of the investigation, discrepancies were found emerging from staff interviews. The home then hired a third party to conduct the investigation. The investigation was completed; however, the home was not able to find out the cause in which resident #001 sustained an injury of altered skin integrity on the identified date.

In an interview, staff #111 acknowledged the home did not protect resident #001 from sustaining an injury. Staff #100 transferred resident #001 unassisted when the care plan indicated the resident required more than one person assistance for transfers. Furthermore, registered staff abandoned resident #001 when the resident was in need of assessment and treatment.

The severity of this noncompliance is actual harm. The scope was isolated to resident #001. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report #2017_595604_0011 on April 26, 2017, and a written notification was issued under inspection report #2016_356618_0013 on May 9, 2016 for s. 19 (1). As a result of actual harm and ongoing of noncompliance, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the braden scale for predicting pressure sore risk assessment dated two days after the admission, completed by staff #105 revealed that resident #001 had potential problem in regards to altered skin integrity.

Review of resident #001's electronic medication administration record (eMAR) for the above mentioned month, and physician's order revealed the resident was prescribed an identified medication at a specified dosage, frequency and route. The eMAR also revealed resident #001 had taken the identified medication for two days after admission.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

Review of an identified critical incident system report (CIS) submitted to the Ministry by the home on an identified date revealed staff #100 discovered and reported to the registered staff that resident #001 had an altered skin integrity on an identified date. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on the above mentioned identified date, staff #100 called staff #102 and showed staff #102 resident #001's injury of altered skin integrity of a specified measurement.

In an interview, staff #100 stated that on the identified date, during meal service, resident #001 was observed not eating, and the resident stated he/she was not feeling well. Staff #100 then transported resident #001 from the dining room to the resident's room after meal service with the mobility device. Staff #100 placed the mobility device at a 90 degrees angle to the toilet by the sink, asked the resident to hold onto the grab bar on the wall on the right side of the toilet to stand up. Then staff #100 assisted the resident to sit down on the toilet. The mobility device was left in the doorway of the washroom. While the resident was sitting on the toilet, staff #100 remained in the washroom and called for assistance in fetching clean clothes and continent care product for the resident. Staff #101 arrived and handed the clean clothes and continent care product to staff #100. When resident #001 finished voiding in the toilet, staff #100 provided peri-care and assisted resident #001 to put the clean continent care product and clothes on, and asked the resident to stand up by holding onto the grab bar, then staff #100 assisted the resident to sit on the mobility device while staff #101 stood behind the mobility device at the doorway of the washroom. Staff #101 then placed the mobility device at the right side of the bed at a 45 degrees angle. Staff #100 asked the resident to stand up by holding onto the right side rail (a quarter length side rail was positioned at a vertical position at that time). Once the resident was standing, staff #101 moved the mobility device to the end of the bed. Staff #100 assisted resident #001 from the resident's left side and the resident turned anti clockwise, then sat down on the bed. Staff #101 left the room when resident #001 was sitting on the edge of the bed. Staff #100 elevated the head of the bed and put both the resident's legs onto the bed, then left the room.

On an identified date, with the assistance of staff #100 and #101, the inspector re-enacted resident #001's transfer that took place on the above mentioned identified date in resident #001's room with the same bed. The inspector was standing by the right side of the bed and holding onto the side rail on the right side of bed. When the inspector turned anti clockwise so that the inspector could sit on the edge of the bed, the

inspector's outer right knee was pressed against the knob and the edge of a flat metal connecting the knob and the bars of the side rail. The inspector observed the edges of the flat metal were not smooth.

In an interview, staff #100 stated he/she was aware of resident #001's care plan indicated the resident required more than one person physical assistance for transfers, and confirmed that he/she transferred resident #001 without assistance from another staff member more than once on the identified date.

In an interview, staff #111 confirmed that staff #100 transferred resident #001 without assistance from another staff member when the written plan of care indicated the resident required more than one person assistance for transfers was an unsafe practice.

B) As a result of identified non-compliance with O. Regulation (O. Reg.) 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #002.

On an identified date, the inspector observed staff #112 and #113 transfer resident #002 from chair to bed with a mechanical lift. The inspector observed staff #112 place the chair by the left side of the bed, remove a sling from the resident's drawer and place it underneath the resident. Staff #112 and #113 hooked the sling to the mechanical lift and lifted the resident up from the chair, moved the resident over the bed, then lowered the resident onto the bed. Staff #112 and #113 then removed the sling, placed the call bell by the pillow and engaged the side rails. The inspector observed the hem of the sling used for transferring resident #002 was green, and an "X" mark indicated it was a large size sling.

Review of resident #002's most recent written plan of care revealed the resident required total assistance with mechanical lift and two staff. The same written plan of care failed to reveal the size of the sling used for the transfer.

In an interview, staff #112 was not able to locate the identification of the size on the sling used to transfer resident #002. Staff #112 stated that by looking at the sling, he/she knew the sling was a large size sling. In addition, by looking at the resident, he/she knew resident #002 needed a large size sling for transfers.

In an interview, staff #114 stated the size of sling used for transfers was based on the individual resident's height and weight. Staff #114 further stated he/she did not know how

many different sizes of slings were used in the home, nor how to assess the appropriate size of sling for a resident.

In an interview, staff #117 stated that the mode of transfer for a resident would be assessed by the physiotherapist, and the nursing team would decide on the size of the sling based on the resident's weight. Staff #117 further stated the guideline in determining the size was on the label of the sling.

C) As a result of identified non-compliance with O. Regulation (O. Reg.) 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #003.

On an identified date, the inspector observed staff #115 and #116 transfer resident #003 from bed to chair with a mechanical lift. The inspector observed a sling was already placed underneath the resident. Staff #115 placed the chair by the right side of the bed, hooked the sling to the mechanical lift and lifted the resident up from the bed, moved the resident over the chair and lowered the resident onto the chair. Staff #115 and #116 then removed the sling. The inspector observed the hem of the sling was yellow. The inspector did not observe a label attached to the sling.

Review of resident #003's most recent care plan revealed the resident required two staff total assistance with mechanical lift for transfers, and the same care plan did not identify the size of the sling used for transfer.

In an interview, staff #115 stated he/she knew the size of the sling used to transfer resident #003 was medium large. The inspector asked staff #115 was the size of the sling a medium or large. Staff #115 stated it was more towards a medium by looking at it. Staff #115 further stated he/she knew that was the right size sling for resident #003 because it fit.

In an interview, staff #116 stated he/she was not aware of who was responsible for assessing the size of the sling for residents who required mechanical lifts for transfers.

In an interview, staff #110 stated all slings were blue, and the colours on the hems of the slings indicated different sizes of the slings. The label attached to the back of each sling included the colour identifications and an "X" mark indicated the size of the sling. Staff #110 stated that the determination of the size of sling used for transfers was a joint effort from the physiotherapy and nursing teams. Staff #110 confirmed that all residents who

required a mechanical lift for transfers should be assessed for the size of sling, and indicated in the written plan of care, and staff should use the proper size of sling to ensure safe transfers. Staff #110 confirmed these were not done for resident #002 and #003 to ensure safe transfers.

The severity of this noncompliance is potential for actual harm. The sample inspected was increased to three residents after noncompliance was identified and the scope was wide spread. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report 2017_653648_0007 on April 19, 2017. As a result, a compliance order is warranted. [s. 36.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A) As a result of identified non-compliance with Ontario Regulation (O. Reg.) 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #002.

On an identified date, the inspector observed staff #112 and #113 transfer resident #002 from chair to bed with a mechanical lift. The inspector observed staff #112 place the chair by the left side of the bed, remove a sling from the resident's drawer and place it underneath the resident. Staff #112 and #113 hooked the sling to the mechanical lift and lifted the resident up from the chair, moved the resident over the bed, then lowered the resident onto the bed. Staff #112 and #113 then removed the sling, placed the call bell by the pillow and engaged the side rails. The inspector observed the hem of the sling used for transferring resident #002 was green, and an "X" mark indicated it was a large size

sling.

Review of resident #002's most recent written plan of care revealed the resident required total assistance with mechanical lift and two staff. The same written plan of care failed to reveal the size of the sling used for the transfer.

In an interview, staff #112 was not able to locate the identification of the size on the sling used to transfer resident #002. Staff #112 stated that by looking at the sling, he/she knew the sling was a large size sling. In addition, by looking at the resident, he/she knew resident #002 needed a large size sling for transfers.

In an interview, staff #114 stated the size of sling used for transfers was based on the individual resident's height and weight. Staff #114 further stated he/she did not know how many different sizes of slings were used in the home, nor how to assess the appropriate size of sling for a resident.

In an interview, staff #117 stated that the mode of transfer for a resident would be assessed by the physiotherapist, and the nursing team would decide on the size of the sling based on the resident's weight. Staff #117 further stated the guideline in determining the size was on the label of the sling.

In an interview, staff #110 stated all slings were blue, and the colours on the hems of the slings indicated different sizes of the slings. The label attached to the back of each sling included the colour identifications and an "X" mark indicated the size of the sling. Staff #110 confirmed that there was no clear direction in regards to the size of sling for resident #002's transfers in the resident's written plan of care.

B) As a result of identified non-compliance with O. Reg. 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #003.

On an identified date, the inspector observed staff #115 and #116 transfer resident #003 from bed to chair with a mechanical lift. The inspector observed a sling was already placed underneath the resident. Staff #115 placed the chair by the right side of the bed, hooked the sling to the mechanical lift and lifted the resident up from the bed, moved the resident over the chair and lowered the resident onto the chair. Staff #115 and #116 then removed the sling. The inspector observed the hem of the sling was yellow. The inspector did not observe a label attached to the sling.

Review of resident #003's most recent care plan revealed the resident required two staff total assistance with mechanical lift for transfers, and the same care plan did not identify the size of the sling used for transfer.

In an interview, staff #115 stated he/she knew the size of the sling used to transfer resident #003 was medium large. The inspector asked staff #115 was the size of the sling a medium or large. Staff #115 stated it was more towards a medium by looking at it. Staff #115 further stated he/she knew that was the right size sling for resident #003 because it fit.

In an interview, staff #116 stated he/she was not aware of who was responsible for assessing the size of the sling for residents who required mechanical lifts for transfers.

In an interview, staff #110 stated all slings were blue, and the colours on the hems of the slings indicated different sizes of the slings. The label attached to the back of each sling included the colour identifications and an "X" mark indicated the size of the sling. Staff #110 confirmed that there was no clear direction in regards to the size of sling for resident #003's transfers in the resident's written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

In an interview, staff #100 stated that he/she was not able to weigh resident #001 on the

day he/she was admitted. Staff #100 also stated that in order to weigh resident #001, resident #001 was asked to stand up from the chair by holding onto the wall rail in the hallway, so that staff #001 could replace the chair with a sitting scale for the resident to sit. Staff #100 further stated that resident #001 was not able to stand for the whole duration for the sitting scale to be placed behind him/her. Staff #100 stated he/she reported to staff #102 that resident #001 required more than one person transfer as he/she had difficulty in standing.

In interviews, staff #102 and #106 denied receiving the above mentioned report.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assist two days after the admission.

In an interview, staff #105 stated that resident #001's care plan in regards to transfer was revised two days after his/her admission to a more than one person assistance for transfers due to the resident's physical and medical status. Staff #105 also stated that when there were changes in regards to a resident's mobility or transfer status, the resident would be referred to the physiotherapist (PT) for re-assessment. Staff #105 confirmed that he/she did not make a referral to the PT for a re-assessment for resident #001 when the resident's written plan of care was revised on the above mentioned date.

In an interview, staff #108 stated physiotherapy assessment, initial or change of conditions, would be completed when the nursing team sent a referral to the physiotherapist. Staff #108 further stated he/she did not receive a report in regards to resident #001's inability to stand for the weight to be measured prior to the initial physiotherapy assessment completed on the day after his/her admission. In addition, staff #108 stated he/she did not receive a referral when resident #001's written plan of care was revised in relation to transfers the day after.

In an interview, staff #110 acknowledged the nursing team and the physiotherapy team did not collaborate with each other in resident #001's mobility and transfer assessments.

The severity of this noncompliance is potential for actual harm. The scope was isolated to resident #001. A review of the home's compliance history revealed voluntary plans of correction had been issued under inspection reports 2017_595604_0011 on April 26, 2017 and 2016_382596_0004 on February 17, 2016; As a result of ongoing noncompliance, a compliance order is warranted. [s. 6. (4) (a)]

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

On an identified date, the MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

In an interview, staff #100 stated that on an identified date, he/she transferred resident #001 from chair to toilet, then toilet to chair without the assistance from another staff member. Staff #100 also stated and demonstrated to the inspector that he/she transferred resident #001 from chair to bed without the assistance from another staff member.

In an interview, staff #101 stated he/she was in the room while staff #100 transferred resident #001 from toilet to chair, and from chair to bed, and he/she did not provide physical assist to transfer the resident. Staff #100 further stated he/she was aware of resident #001's care plan which indicated the resident required more than one person physical assist for transfers, and confirmed that he/she had transferred resident #001 without assistance from another staff member more than once on the identified date.

In an interview, PT #108 stated a two-person assist transfer meant that two staff members must physically assist a resident for transfers.

In an interview, staff #111 confirmed that care set out in resident #001's plan of care was not provided when staff #100 transferred resident #001 without assistance from another staff member when the care plan indicated the resident required more than one person assistance for transfers.

The severity of this noncompliance is potential for actual harm. The scope was isolated to resident #001. A review of the home's compliance history revealed voluntary plans of correction had been issued under inspection reports 2017_595604_0011 on April 26, 2017, 2016_382596_0004 on February 17, 2016 and 2015_268604_0011 on July 2, 2015. As a result of ongoing noncompliance, a compliance order is warranted. [s. 6. (7)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On an identified date, the inspector observed resident #004 in the basement of the home.

During the course of the inspection, the inspector observed there were keypads in the elevators, and a code is required to operate the elevators to go to the basement level. During the course of the inspection, the inspector did not observe any mal-functioning of the keypads. The maintenance workshop, laundry room, education room, staff office and staff lounge were located in the basement.

Resident #004 was not interviewable due to his/her cognitive status and language barrier.

In an interview, staff #119 stated that he/she had seen resident #004 in the basement a few times prior to the above mentioned identified date, and staff #119 did not know whether the resident was aware of the code of the elevator to the basement or the resident followed other staff member(s) to the basement level. Staff #119 further stated that he/she was aware that residents were restricted to access to basement level without supervision.

In an interview, staff #111 acknowledged that interventions should have been implemented to restrict resident access to areas that are not to be accessed by residents to ensure the safety of the residents. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, the MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of an identified CIS submitted to the Ministry by the home on an identified date, revealed staff #100 discovered and reported to the registered staff that resident #001 had an altered skin integrity on an identified date. The incident was reported to the Ministry two days later by sending an email to Centralized Intake Assessment and Triage Team (CIATT) by staff #110. The CIS further revealed the resident was sent to the hospital for treatment.

Review of the home's policy titled, "abuse and neglect" (index I.D: RCS P-10, revised July 2, 2015, revealed the following:
- Where a staff member has reason to believe that a resident has suffered harm or at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the home, and to the director appointed under the Long-Term Care Homes Act, 2007 (LTCHA).
- Staff must adhere to the mandatory reporting obligations set out in the LTCHA, which include the above described reports.
- The home will immediately investigate any allegations of harm or potential harm to a resident, including as caused by abuse or neglect, and will thereafter take all appropriate actions.
- Upon discovering an incident of suspected or witnessed abuse, a staff member is to prepare a written report (suspected abuse/ neglect report), which contains the following information and is to be provided to their supervisor:
o What occurred,
o When it occurred,
o Who was involved, including witnesses,
o Where it occurred, and
o Any other relevant information.
- Any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the administrator/ designate of the home, who will immediately commence an investigation.

In an interview, staff #100 stated that on the identified date, when he/she did his/her round and observed resident #001's altered skin integrity, staff #100 called out for the nurse.

In interviews, staff #102, #106 and #107 stated that on the identified date, they were informed of an injury to resident #001. All three staff had observed resident #001's injury and acknowledged the following actions were not taken:
- immediate investigation on the injury with unknown cause,
- notify the on-call manager,
- notify the Ministry,
- notify the police, and
- prepare a written report of the incident.

In an interview, staff #111 stated on an identified date, the management team became

aware of the injury to resident #001 who was found to have an altered skin integrity that resulted in transfer to hospital two days prior. Staff #111 confirmed that staff did not follow the home's "abuse and neglect" policy when resident #001's injury was discovered on the identified date. [s. 20. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that is reported to the licensee, was immediately investigated:
(i) Abuse of a resident by anyone, or
(ii) Neglect of a resident by the licensee of staff.

On an identified date, the MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the identified CIS submitted to the Ministry by the home on an identified date, revealed staff #100 discovered and reported to staff that resident #001 had an altered skin integrity two days prior. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on the identified date, staff #100 called and showed staff #102 resident #001's altered skin integrity of a specified measurement.

In an interview, staff #100 stated that on the identified date, he/she observed and showed staff #102 resident #001's injury of altered skin integrity.

In interviews, staff #102, #106 and #107 stated that on the identified date, they were aware of the injury to resident #001. All three staff had observed resident #001's injury of altered skin integrity and acknowledged immediate investigation of the injury with unknown cause was not initiated.

In an interview, staff #111 stated on an identified date, the management team became aware of the incident of resident #001 who was found with an injury of altered skin integrity and was transferred to hospital for treatment two days prior. Staff #111 confirmed that the investigation should have been initiated immediately upon the discovery of the injury to resident #001's injury on the identified date. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of the following that the licensee knew of, or that is reported to the licensee, is immediately investigated:
(i) Abuse of a resident by anyone, or
(ii) Neglect of a resident by the licensee of staff., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to report immediately the suspicion of any of the following has occurred or might occur and the information upon which it was 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.
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.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.

On an identified date, MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the identified CIS submitted to the Ministry by the home on the identified date, revealed staff #100 discovered and reported that resident #001 had an altered skin integrity on an identified date. The incident was reported to the Ministry two days later by sending an email to CIATT by staff #110. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on an identified date, staff #100 called and showed staff #102 resident #001's injury of altered skin integrity of a specified measurement.

In an interview, staff #100 stated that on an identified date, he/she observed and showed staff #102 resident #001's injury of altered skin integrity.

In interviews, staff #102, #106 and #107 stated that on the identified date, they were notified of the injury of altered skin integrity to resident #001. All three staff had observed resident #001's injury and acknowledged none of them reported the incident to the Ministry as required.

In an interview, staff #111 stated on an identified date, the management team became aware of the injury of altered skin integrity sustained by resident #001 that required transfer to hospital for treatment two days prior. Staff #111 confirmed that the incident should have been reported to the Ministry immediately, not two days later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to report immediately the suspicion of any of the following has occurred or may occur 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
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
3. Unlawful conduct that resulted in harm or risk of harm to a resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects might constitute a criminal offence.

On an identified date, the MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the identified CIS submitted to the Ministry by the home on an identified date, revealed staff #100 discovered and reported that resident #001 had an altered skin integrity on an identified date. The incident was reported to the Ministry two days later by sending an email to CIATT by staff #110. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on an identified date, staff #100 called showed staff #102 resident #001's injury of altered skin integrity.

Further review of resident #001's progress notes revealed police were notified of the above mentioned incident two days later.

In an interview, staff #100 stated that on the identified date, he/she observed and showed staff #102 resident #001's injury of altered skin integrity.

In interviews, staff #102, #106 and #107 stated that they were aware of the injuries of resident #001. All three staff had observed resident #001's injury of altered skin integrity and acknowledged police were not notified of the incident on the same day.

In an interview, staff #111 stated on an identified date, the management team became aware of the injury of altered skin integrity sustained by resident #001 which required transfer to hospital for treatment. Staff #111 confirmed that the police should have been notified of the incident immediately, not two days later. [s. 98.]

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

Issued on this 1st day of December, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2017_644507_0016
Log No. / No de registre :	025027-17, 025087-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 29, 2017
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	HAWTHORNE PLACE CARE CENTRE 2045 FINCH AVENUE WEST, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Joseph-Massiah

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Upon receipt of this Compliance Order the licensee shall prepare, submit and implement a plan to ensure that all residents are protected from physical abuse and neglect from staff. The plan shall include, but is not limited to the following:

1. Provide re-education and training to all staff on the Home's policy to promote zero tolerance of abuse and neglect, and include a sign up sheet with signature of attendees be kept on file. The training is to include the following items:
a) definitions of the different types of abuse,
b) reporting requirements for all staff if they become aware of an incident of abuse or neglect, and
c) role of the registered staff upon becoming aware of an allegation of abuse as it relates to investigation of the allegation and notification of the appropriate individuals consistent with legislative time lines.
2. Develop and implement a written quality improvement process to audit, monitor and analyze the level of compliance by registered staff to the requirements set out in the Home's zero tolerance policy as well as the responsibilities of all staff upon becoming aware of an incident or allegation of abuse.
3. Maintain a written record of the quality improvement process that identifies when the Home policy was not complied with and the steps taken by the licensee when non-compliance with the home's policy.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 8, 2017.

Grounds / Motifs :

1. The licensee has failed to protect resident #001 from abuse and neglect from staff.

A) On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the braden scale for predicting pressure sore risk assessment dated two days after the admission, completed by staff #105 revealed that resident #001 had potential problem in regards to altered skin integrity.

Review of resident #001's electronic medication administration record (eMAR) for the above mentioned month, and physician's order revealed the resident was prescribed an identified medication at a specified dosage, frequency and route. The eMAR also revealed resident #001 had taken the identified medication for two days after admission.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

Review of an identified critical incident system report (CIS) submitted to the Ministry by the home on an identified date revealed staff #100 discovered and reported to the registered staff that resident #001 had an altered skin integrity on an identified date. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on the above mentioned identified date, staff #100 called staff #102 and showed staff #102 resident #001's altered skin integrity of a specified measurement.

B) In an interview, staff #105 stated that resident #001's written plan of care in regards to transfer was revised two days after the admission due to the resident's physical and medical status.

In an interview, staff #100 stated that on the identified date, during meal service, resident #001 was observed not eating, and the resident stated he/she was not feeling well. Staff #100 then transported resident #001 from the dining room to the resident's room after meal service with the mobility device. Staff #100 placed the mobility device at a 90 degrees angle to the toilet by the sink, asked the resident to hold onto the grab bar on the wall on the right side of the toilet to stand up. Then staff #100 assisted the resident to sit down on the toilet. The mobility device was left in the doorway of the washroom. While the resident was sitting on the toilet, staff #100 remained in the washroom and called for assistance in fetching clean clothes and continent care product for the resident. Staff #101 arrived and handed the clean clothes and continent care product to staff #100. When resident #001 finished voiding in the toilet, staff #100 provided peri-care and assisted resident #001 to put the clean continent care product and clothes on, and asked the resident to stand up by holding onto the grab bar, then staff #100 assisted the resident to sit on the mobility device while staff #101 stood behind the mobility device at the doorway of the washroom. Staff #101 then placed the mobility device at the right side of the bed at a 45 degrees angle. Staff #100 asked the resident to stand up by holding onto the right side rail (a quarter length side rail was positioned at a vertical position at that time). Once the resident was standing, staff #101 moved the mobility device to the end of the bed. Staff #100 assisted resident #001 from the resident's left side and the resident turned anti clockwise, then sat down on the bed. Staff #101 left the room when resident #001 was sitting on the edge of the bed. Staff #100 elevated the head of the bed and put both the resident's legs onto the bed, then left the room.
Approximately an hour later, staff #100 did his/her round and observed #001 had altered skin integrity. Staff #100 reported to staff #102.

In an interview, staff #102 stated that on the identified date, he/she was called by

staff #100 to resident #001's room. When arrived, staff #102 saw resident #001's altered skin integrity and asked staff #100 what happened, and staff #100 responded he/she did not know what happened. Staff #102 then went to the nursing station and asked staff #106 to measure and cover resident #001's altered skin integrity. Staff #102 then called for the ambulance and left a voice message for resident #001's family.

In an interview, staff #106 stated that on the identified date, he/she was told by staff #102 that resident #001 had an altered skin integrity and asked him/her to measure and cover the affected area. Staff #106 gathered some dressing supplies and went to another unit on the first floor for a paper measuring tape as there was none on the unit. When staff #106 returned to the unit and arrived at resident #001's room, he/she saw an altered skin integrity. Staff #106 further described the altered skin integrity and stated it was so bad that he/she could not look at it to measure. Staff #106 then left resident #001's room and went to the nursing station, used the phone to call the facility charge nurse to arrive at resident #001's room.

In an interview, staff #107 stated that on the identified date, staff #106 called and asked him/her to arrive at resident #001's room. When staff #107 arrived, staff #100, #101, and #106 were in the room, staff #106 gave him/her the paper measuring tape and asked him/her to measure resident #001's altered skin integrity. Staff #107 measured the affected area and told staff #106 the measurement. Staff #107 covered the affected area with dressing.

C) In interviews, staff #100, #101, #102, #106 and #107 denied any knowledge of what happened to resident #001 that caused the injury from the time the resident left the dining room to when the altered skin integrity was discovered.

In an interview, staff #100 denied any falls or injuries resident #001 experienced during transfers on the identified date.

On an identified date, with the assistance of staff #100 and #101, the inspector re-enacted resident #001's transfer that took place on the above mentioned identified date in resident #001's room with the same bed. The inspector was standing by the right side of the bed and holding onto the side rail on the right side of bed. When the inspector turned anti clockwise so that the inspector could sit on the edge of the bed, the inspector's outer right knee was pressed against the knob and the edge of a flat metal connecting the knob and the bars of the

side rail. The inspector observed the edges of the flat metal were not smooth. Staff #100 acknowledged resident #001's care plan indicated the resident required extensive assistance for transfer, and he/she transferred resident #001 without assistance of another staff member on the identified date.

In an interview, staff #102 stated that on the identified date, when he/she was called to resident #001's room and discovered the injury, he/she did not assess the resident, nor use the call bell to request assistance from other staff. Instead, staff #102 left the resident who had an injury, went to the nursing station and asked the staff #106 to measure and cover the affected area.

In an interview, staff #106 stated that on the identified date, he/she was asked by staff #102 to measure and cover resident #001's altered skin integrity. When he/she arrived at resident #001's room and saw the injury, he/she did not measure and cover the affected area nor assess the resident. Instead, staff #106 left the resident who had an injury, went to the nursing station and used the phone to call the facility charge nurse to arrive at the resident's room. Staff #106 also stated when he/she returned, he/she asked the resident was he/she OK, the resident opened his/her eyes, said something then closed his/her eyes. Staff #106 stated he/she was not able to hear what resident #001 said, but he/she did not further assess the resident.

In an interview, staff #111 stated two days after the above mentioned incident, the management team became aware of the incident involving resident #001 who was found with an injury of altered skin integrity two days prior. The home initiated the investigation and notified the police and the Ministry. Staff #111 further stated that during the beginning of the investigation, discrepancies were found emerging from staff interviews. The home then hired a third party to conduct the investigation. The investigation was completed; however, the home was not able to find out the cause in which resident #001 sustained an injury of altered skin integrity on the identified date.

In an interview, staff #111 acknowledged the home did not protect resident #001 from sustaining an injury. Staff #100 transferred resident #001 unassisted when the care plan indicated the resident required more than one person assistance for transfers. Furthermore, registered staff abandoned resident #001 when the resident was in need of assessment and treatment.

The severity of this noncompliance is actual harm. The scope was isolated to

resident #001. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report #2017_595604_0011 on April 26, 2017, and a written notification was issued under inspection report #2016_356618_0013 on May 9, 2016 for s. 19 (1). As a result of actual harm and ongoing of noncompliance, a compliance order is warranted. [s. 19. (1)] (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

Upon receipt of this Compliance Order the licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The plan shall include, but is not limited to the following:

1. Identify all residents in the home that require the use of a mechanical lift along with the specific size sling to be used for transfer purposes.
2. Provide education and training to all direct care staff on safe transfers.
3. Review with direct care staff, each resident who requires assistance for transferring, the method and devices to be used as outlined in the resident's written plan of care, and maintain a record of the review.
4. Develop and implement an auditing system to ensure that direct care staff assist residents with transferring using the method and devices which are included in the resident's plan of care.
5. Include in the compliance plan a system that outlines how the licensee will monitor staff adherence to safe transfer of residents.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 8, 2017.

Grounds / Motifs :

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

A) On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Interview with resident #001's substitute decision-maker (SDM) revealed that resident #001 was admitted to the home on an identified date and was found with an altered skin integrity three days later.

Review of the braden scale for predicting pressure sore risk assessment dated two days after the admission, completed by staff #105 revealed that resident #001 had potential problem in regards to altered skin integrity.

Review of resident #001's electronic medication administration record (eMAR) for the above mentioned month, and physician's order revealed the resident was prescribed an identified medication at a specified dosage, frequency and route. The eMAR also revealed resident #001 had taken the identified medication for two days after admission.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

Review of an identified critical incident system report (CIS) submitted to the Ministry by the home on an identified date revealed staff #100 discovered and reported to the registered staff that resident #001 had an altered skin integrity on an identified date. The CIS further revealed the resident was sent to the hospital for treatment.

Review of resident #001's progress notes documented by staff #102 revealed that on the above mentioned identified date, staff #100 called staff #102 and showed staff #102 resident #001's injury of altered skin integrity of a specified measurement.

In an interview, staff #100 stated that on the identified date, during meal service, resident #001 was observed not eating, and the resident stated he/she was not feeling well. Staff #100 then transported resident #001 from the dining room to the resident's room after meal service with the mobility device. Staff #100 placed the mobility device at a 90 degrees angle to the toilet by the sink, asked the resident to hold onto the grab bar on the wall on the right side of the toilet to stand up. Then staff #100 assisted the resident to sit down on the toilet. The mobility device was left in the doorway of the washroom. While the resident was sitting on the toilet, staff #100 remained in the washroom and called for assistance in fetching clean clothes and continent care product for the resident. Staff #101 arrived and handed the clean clothes and continent care product to staff #100. When resident #001 finished voiding in the toilet, staff #100 provided peri-care and assisted resident #001 to put the clean continent care product and clothes on, and asked the resident to stand up by holding onto the grab bar, then staff #100 assisted the resident to sit on the mobility device while staff #101 stood behind the mobility device at the doorway of the washroom. Staff #101 then placed the mobility device at the right side of the bed at a 45 degrees angle. Staff #100 asked the resident to stand up by holding onto the right side rail (a quarter length side rail was positioned at a vertical position at that time). Once the resident was standing, staff #101 moved the mobility device to the end of the bed. Staff #100 assisted resident #001 from the resident's left side and the resident turned anti clockwise, then sat down on the bed. Staff #101 left the room when resident #001 was sitting on the edge of the bed. Staff #100 elevated the head of the bed and put both the resident's legs onto the bed, then left the room.

On an identified date, with the assistance of staff #100 and #101, the inspector re-enacted resident #001's transfer that took place on the above mentioned identified date in resident #001's room with the same bed. The inspector was standing by the right side of the bed and holding onto the side rail on the right side of bed. When the inspector turned anti clockwise so that the inspector could sit on the edge of the bed, the inspector's outer right knee was pressed against the knob and the edge of a flat metal connecting the knob and the bars of the side rail. The inspector observed the edges of the flat metal were not smooth.

In an interview, staff #100 stated he/she was aware of resident #001's care plan indicated the resident required more than one person physical assistance for transfers, and confirmed that he/she transferred resident #001 without assistance from another staff member more than once on the identified date.

In an interview, staff #111 confirmed that staff #100 transferred resident #001 without assistance from another staff member when the written plan of care indicated the resident required more than one person assistance for transfers was an unsafe practice.

B) As a result of identified non-compliance with O. Regulation (O. Reg.) 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #002.

On an identified date, the inspector observed staff #112 and #113 transfer resident #002 from chair to bed with a mechanical lift. The inspector observed staff #112 place the chair by the left side of the bed, remove a sling from the resident's drawer and place it underneath the resident. Staff #112 and #113 hooked the sling to the mechanical lift and lifted the resident up from the chair, moved the resident over the bed, then lowered the resident onto the bed. Staff #112 and #113 then removed the sling, placed the call bell by the pillow and engaged the side rails. The inspector observed the hem of the sling used for transferring resident #002 was green, and an "X" mark indicated it was a large size sling.

Review of resident #002's most recent written plan of care revealed the resident required total assistance with mechanical lift and two staff. The same written plan of care failed to reveal the size of the sling used for the transfer.

In an interview, staff #112 was not able to locate the identification of the size on the sling used to transfer resident #002. Staff #112 stated that by looking at the sling, he/she knew the sling was a large size sling. In addition, by looking at the resident, he/she knew resident #002 needed a large size sling for transfers.

In an interview, staff #114 stated the size of sling used for transfers was based on the individual resident's height and weight. Staff #114 further stated he/she did not know how many different sizes of slings were used in the home, nor how to assess the appropriate size of sling for a resident.

In an interview, staff #117 stated that the mode of transfer for a resident would be assessed by the physiotherapist, and the nursing team would decide on the size of the sling based on the resident's weight. Staff #117 further stated the guideline in determining the size was on the label of the sling.

C) As a result of identified non-compliance with O. Regulation (O. Reg.) 79/10, s. 36, the sample of residents inspected related to safe transferring and positioning techniques was expanded to include resident #003.

On an identified date, the inspector observed staff #115 and #116 transfer resident #003 from bed to chair with a mechanical lift. The inspector observed a sling was already placed underneath the resident. Staff #115 placed the chair by the right side of the bed, hooked the sling to the mechanical lift and lifted the resident up from the bed, moved the resident over the chair and lowered the resident onto the chair. Staff #115 and #116 then removed the sling. The inspector observed the hem of the sling was yellow. The inspector did not observe a label attached to the sling.

Review of resident #003's most recent care plan revealed the resident required two staff total assistance with mechanical lift for transfers, and the same care plan did not identify the size of the sling used for transfer.

In an interview, staff #115 stated he/she knew the size of the sling used to transfer resident #003 was medium large. The inspector asked staff #115 was the size of the sling a medium or large. Staff #115 stated it was more towards a medium by looking at it. Staff #115 further stated he/she knew that was the right size sling for resident #003 because it fit.

In an interview, staff #116 stated he/she was not aware of who was responsible for assessing the size of the sling for residents who required mechanical lifts for transfers.

In an interview, staff #110 stated all slings were blue, and the colours on the hems of the slings indicated different sizes of the slings. The label attached to the back of each sling included the colour identifications and an "X" mark indicated the size of the sling. Staff #110 stated that the determination of the size of sling used for transfers was a joint effort from the physiotherapy and nursing teams. Staff #110 confirmed that all residents who required a mechanical lift for transfers should be assessed for the size of sling, and indicated in the written plan of care, and staff should use the proper size of sling to ensure safe transfers. Staff #110 confirmed these were not done for resident #002 and #003 to ensure safe transfers.

The severity of this noncompliance is potential for actual harm. The sample inspected was increased to three residents after noncompliance was identified and the scope was wide spread. A review of the home's compliance history revealed a voluntary plan of correction had been issued under inspection report 2017_653648_0007 on April 19, 2017. As a result, a compliance order is warranted. [s. 36.] (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

Upon receipt of this Compliance Order the licensee shall prepare and submit a plan to ensure that staff and others involved in the different aspects of resident care collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement with each other.

The plan will include, but is not limited to the following:
1. Provide education and training to all staff that includes the definition and importance of collaboration in assessment.
2. Develop and implement a quality improvement process to audit, monitor and analyze the level of compliance by staff to ensure that staff and others involved in the different aspects of resident care collaborate with each other in the assessment of the resident.
3. Include in the compliance plan a system that outlines how the licensee will monitor staff adherence to collaboration in residents' assessments.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 8, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the

assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to an injury sustained by resident #001 with no known cause.

Review of resident #001's progress notes revealed the initial physiotherapy assessment was not completed on the day the resident was admitted. The progress notes further revealed staff #108 recommended the resident to have staff assist for transfers and a mobility device was provided to the resident for locomotion purpose. Review of the physiotherapy initial assessment completed on the next day after admission completed by staff #108 revealed that resident #001 required assistance for changing positions and physical support for standing. The same physiotherapy assessment indicated resident #001 required staff assist for transfers.

In an interview, staff #100 stated that he/she was not able to weigh resident #001 on the day he/she was admitted. Staff #100 also stated that in order to weigh resident #001, resident #001 was asked to stand up from the chair by holding onto the wall rail in the hallway, so that staff #001 could replace the chair with a sitting scale for the resident to sit. Staff #100 further stated that resident #001 was not able to stand for the whole duration for the sitting scale to be placed behind him/her. Staff #100 stated he/she reported to staff #102 that resident #001 required more than one person transfer as he/she had difficulty in standing.

In interviews, staff #102 and #106 denied receiving the above mentioned report.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assist two days after the admission.

In an interview, staff #105 stated that resident #001's care plan in regards to transfer was revised two days after his/her admission to a more than one person assistance for transfers due to the resident's physical and medical status. Staff #105 also stated that when there were changes in regards to a resident's mobility or transfer status, the resident would be referred to the physiotherapist (PT) for re-assessment. Staff #105 confirmed that he/she did not make a referral to the PT for a re-assessment for resident #001 when the resident's written plan

of care was revised on the above mentioned date.

In an interview, staff #108 stated physiotherapy assessment, initial or change of conditions, would be completed when the nursing team sent a referral to the physiotherapist. Staff #108 further stated he/she did not receive a report in regards to resident #001's inability to stand for the weight to be measured prior to the initial physiotherapy assessment completed on the day after his/her admission. In addition, staff #108 stated he/she did not receive a referral when resident #001's written plan of care was revised in relation to transfers the day after.

In an interview, staff #110 acknowledged the nursing team and the physiotherapy team did not collaborate with each other in resident #001's mobility and transfer assessments.

The severity of this noncompliance is potential for actual harm. The scope was isolated to resident #001. A review of the home's compliance history revealed voluntary plans of correction had been issued under inspection reports 2017_595604_0011 on April 26, 2017 and 2016_382596_0004 on February 17, 2016; As a result of ongoing noncompliance, a compliance order is warranted. [s. 6. (4) (a)] (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

Upon receipt of this Compliance Order the licensee shall prepare and submit a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan will include, but is not limited to the following:
1. Develop and implement a monitoring process that ensures residents are transferred safely as outlined in the plan of care,
2. Develop and implement a quality improvement process to audit, monitor and analyze the level of compliance by direct care staff to ensure resident care is provided as specified in each resident's plan of care.
3. Include in the compliance plan a system that outlines how the licensee will monitor staff adherence to ensure residents are provided the required care as set out in each resident's plan of care.

The plan must be submitted to inspector Stella Ng via email at stella.ng@ontario.ca by December 8, 2017.

Grounds / Motifs :

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

On an identified date, the MOHLTC received a complaint in regards to an injury sustained by resident #001 with no identified cause.

Review of resident #001's written plan of care revealed intervention for transfers was changed to more than one person assistance two days after the admission.

In an interview, staff #100 stated that on an identified date, he/she transferred resident #001 from chair to toilet, then toilet to chair without the assistance from another staff member. Staff #100 also stated and demonstrated to the inspector that he/she transferred resident #001 from chair to bed without the assistance from another staff member.

In an interview, staff #101 stated he/she was in the room while staff #100 transferred resident #001 from toilet to chair, and from chair to bed, and he/she did not provide physical assist to transfer the resident. Staff #100 further stated he/she was aware of resident #001's care plan which indicated the resident required more than one person physical assist for transfers, and confirmed that he/she had transferred resident #001 without assistance from another staff member more than once on the identified date.

In an interview, PT #108 stated a two-person assist transfer meant that two staff members must physically assist a resident for transfers.

In an interview, staff #111 confirmed that care set out in resident #001's plan of care was not provided when staff #100 transferred resident #001 without assistance from another staff member when the care plan indicated the resident required more than one person assistance for transfers.

The severity of this noncompliance is potential for actual harm. The scope was isolated to resident #001. A review of the home's compliance history revealed voluntary plans of correction had been issued under inspection reports 2017_595604_0011 on April 26, 2017, 2016_382596_0004 on February 17, 2016 and 2015_268604_0011 on July 2, 2015. As a result of ongoing noncompliance, a compliance order is warranted. [s. 6. (7)] (507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

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
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 29th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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