Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 10, 2020	2019_641665_0024	016077-19, 017364-19, 017513-19, 018068-19, 022361-19, 023140-19, 023458-19, 023491-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Humber Heights
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 11, 13, 16-20, 23, 24, 30, 31, 2019, January 2 and 3, 2020. Off site January 8-10 and 14, 2020.

The following critical incident system (CIS) intakes were inspected:
- Log #016077-19/CIS #2957-000044-19, Log #023140-19/CIS #2957-000056-19, and Log #023491-19/CIS #2957-000060-19 - related to fall prevention and management;
- Log #018068-19/CIS #2957-000052-19 and Log #023458-19/CIS #2957-000059-19 - related to transferring and positioning;
- Log #017364-19/CIS #2957-000047-19 and Log #017513-19/CIS #2957-000051-19 - related to prevention of abuse and neglect;
- Log #022361-19/CIS #2957-000054-19 - related to hospitalization and change in condition.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Interim Director of Nursing Care (IDNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinators (NC), Kinesiologist (KN), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspector conducted resident observations, observed staff and resident interactions, reviewed clinical health records, the home's investigation documents, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #003 collaborated with each other, in the implementation and development of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

The Ministry of Long Term Care (MLTC) received a CIS report for an incident that caused an injury to resident #003 for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIS report documented that the resident had a fall on an identified date and time in 2019, and was transferred to hospital. The resident sustained an injury and returned to the home 6 days later. At the time of the fall, the resident used a specified mobility device to ambulate.

The review of the resident's most recent resident assessment instrument-minimum data set (RAI-MDS) assessment prior to the fall, documented under physical functioning and structural problems, that the test for balance in a specified position was not able to be attempted without physical help.

A review of the transfer assessment prior to the fall was completed by KN #111 which identified the resident's balance status and was at risk for falls.

A review of the resident’s fall risk assessment 14 days prior to the fall indicated that the resident was at an identified risk of falls and identified the same balance status mentioned above on walking or turning.

A review of resident #003’s written plan of care at the time of the fall did not include documentation of the resident's balance.

In an interview, PSW #121 stated that resident #003 was at risk of falls and ambulated with the specified mobility device prior to the fall. On the day of the fall, the PSW was getting the resident ready for bed when the resident fell in an identified area of their room. The PSW stated they left the resident and went to prepare the resident’s bed. The resident was performing a specified activity of daily living (ADL) in a specified position when they fell. It was the PSW’s understanding that the resident could be left alone and was independent.

In an interview, PSW #130 stated that they were the full time PSW on an identified shift for resident #003 before and after the fall. They indicated that the resident was at risk for falls due to their balance status. The PSW stated when they provided personal care to the resident, the resident was never left alone due to the resident’s balance status and risk for falls. They were beside the resident at all times to ensure the resident did not fall.

In an interview, PT #116 stated they were familiar with resident #003 before and after their fall. The PT indicated the resident was at risk for falls and had the identified balance status with and without the use of the specified mobility device prior to the fall. PT #116 further stated that whenever staff provided personal care to the resident, they should always be with the resident, due to the resident’s balance status and risk for falls.

In an interview, IDNC #100 indicated it was the home’s process when assessments were completed by the registered staff and/or transfer assessments were completed by the kinesiologist, the plan of care was to be updated to ensure that the registered staff and PSWs were aware of the resident’s status and any interventions to be provided. The IDNC reviewed the assessments mentioned above and the resident’s written plan of care and stated the resident’s identified balance status should have been documented and implemented in the care plan to ensure the PSWs were made aware of the assessments

completed and any interventions. The IDNC acknowledged that staff did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care was integrated and was consistent with and complemented each other for resident #003. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

The MLTC received a CIS report for a fall resident #005 had on an identified date in 2019. The CIS report indicated that the resident was found lying on the floor in the hallway in front of their bedroom at an identified time, and was assessed by RPN #108. Few hours later, RN #105 observed the resident rubbing a specified area of their body and complaining of pain, and injury was observed. The resident was transferred to hospital to treat an identified injury. At the time of the inspection, the resident was no longer in the home.

A review of the resident's plan of care documented that the resident was at risk for falls for non-compliance with mobility aide use, health condition and a history of falls prior to admission. The plan of care directed staff to ensure a specified fall intervention was in place to prevent risk of injury from potential falls.

A fall risk assessment was completed two and a half months prior to the resident's fall indicating that the resident was at an identified risk for falls.

In an interview, PSW #125 confirmed that they were the assigned full time PSW for resident #005 at the time of the resident's fall. The PSW stated that they did not implement the specified fall intervention when they provided personal care to the resident prior to the resident's fall. The PSW reviewed the written plan of care and acknowledged that the resident was to have the specified intervention implemented.

In separate interviews, RPN #108 indicated that the resident was a risk for falls. On the day of the fall, they found the resident outside their bedroom door. The RPN indicated they assessed the resident after the fall and the resident was able to stand up, but complained of pain. Two to three hours later, the resident was seen rubbing a specified area of their body and found to have injury; they were then transferred to hospital. RPN #108 indicated initially that the resident had the specified intervention in place when they assessed the resident right after the fall, however, the RPN stated that if they did not document the specified intervention in the falls incident report, then the specified

intervention was not implemented at the time of the fall. The inspector informed the RPN that the falls incident report, did not include documentation regarding the specified intervention. The RPN stated, since they did not document the specified intervention in the falls incident report it was not implemented at the time of resident #005's fall.

A review of the falls incident report, by RPN #108 did not include documentation about the resident's specified intervention.

In an interview, IDNC #100 indicated that resident #005 ambulated with a specified mobility device at the time of their fall. The IDNC reviewed the resident's plan of care and stated that the resident was to have the specified intervention to reduce resident #005's injury from falls. As a result of the fall, the IDNC indicated that the resident had a significant change in health status as the resident sustained an identified injury. The IDNC acknowledged that PSW #125 did not follow the plan of care for resident #005.

This non-compliance is issued since PSW #125 failed to follow the plan of care for resident #005. [s. 6. (7)]

3. The licensee has failed to ensure that the staff and others who provided direct care to residents #004, #003, #001 and #006 were kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it.

1) The MLTC received a CIS report related to a fall resident #004 sustained on an identified date in 2019. The CIS report documented that resident #004 fell from the sling of a total mechanical lift (TML) while being transferred by PSWs #122 and #123. A specified side of the sling holding one area of the resident's body slipped off the TML, which resulted in the resident’s fall onto the floor. The resident was transferred to hospital and returned to the home the following day, diagnosed with identified injuries from the fall.

A review of resident #004’s current written plan of care and kardex on a specified date in December 2019, documented that the resident required a TML for transfers. The written plan of care and kardex did not include documentation on the sling size to be used for resident #004’s transfers.

A review of the most current transfer assessment, by KN #111 documented that the resident was to be transferred with a TML, with a specified sling size.

2) The MLTC received a CIS report for an incident that caused an injury to resident #003 for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIS report documented that the resident had a fall in an identified area of their room on an identified date and time in 2019, and was transferred to hospital. The resident sustained an injury and returned to the home six days later. At the time of the fall, the resident used a a specified mobility device to ambulate.

A review of resident #003's current written plan of care on a specified date in December, 2019, documented that the resident required a TML for transfers. The written plan of care did not have documentation on the sling size to be used for resident #003's transfers.

A review of the current transfer assessment, by KN #111 documented that the resident was to be transferred with a TML with a specified sling size.

A transfer observation was conducted by Inspector #665 on the specified date mentioned above. Resident #003 was transferred from bed to an identified mobility device with the use of an identified TML. It was observed that the sling used was in the resident's room.

After the transfer observation was conducted, separate interviews were conducted with PSW #114 and RPN #112 who transferred the resident. PSW #114 stated that the size of the sling to be used for transfers was documented in the resident's kardex in point of care (POC). There was usually a sling in the room with the resident's name that was to be used for the resident. RPN #112 also indicated that the sling to be used and the sling size was documented in the resident's care plan and in the kardex for the PSWs. In the interview, PSW #114 reviewed the resident's kardex with the inspector and the sling size was not documented. RPN #112 also reviewed the care plan of the resident and the sling size was not documented. Both staff stated that the sling size should have been documented in the care plan and kardex.

In an interview after the transfer observation was conducted on the specified date in December 2019, KN #111 indicated they conduct transfer assessments for residents in the home. They stated that for residents who required TML for transfers, they document the sling size in the care plan under the transfer focus. KN #111 showed the inspector resident #003's care plan and clicked on the edit button under the transfer intervention. There was a text box titled "instruction" which documented the sling size. The information documented in the instruction text box did not populate into the resident's kardex and the care plan. The KN was not aware that the documented sling sizes in the "instruction" text box did not get populated into the residents' kardex and care plan for convenient and

immediate access by the registered staff and PSWs.

3) A review of resident #001's current written plan of care and kardex on the specified date in 2019, noted above, documented that the resident required a TML for transfers. The written plan of care and kardex did not include documentation on the sling size to be used for resident #001's transfers.

A review of the current transfer assessment by KN #111 documented that the resident was to be transferred with a TML, with a specified sling size.

4) A review of resident #006's written plan of care, documented that the resident was to be transferred with a TML for transfers. The written plan of care did not have documentation on the sling size to be used for resident #006's transfers. On the same specified date in 2019, the plan of care was revised documenting the resident required a TML for transfers, with an identified sling size.

The information above was shared with AGM #106 and IDNC #100 on the specified date in 2019. Both indicated that the size of the sling for transfers must be documented in the care plan and must be easily accessible for staff. The IDNC further indicated that the registered staff would click the edit button only when the care plan was being revised.

In interviews, IDNC #100 confirmed that the documentation by KN #111 in the instruction text box did not get populated into the kardex and in the care plan for the PSWs and registered staff to see. When it was brought to their attention by the inspector on the specified date, the home immediately reviewed the care plans for all residents who were transferred with a mechanical lift and updated the care plans to include the size of the sling to be used, so that the PSWs and the registered staff had immediate access to the information. The IDNC indicated there were 80 residents' plans of care and kardexes affected, and provided the inspector with a report. The review of the report included resident #006. IDNC #100 confirmed that the direct care staff (PSWs and registered staff) did not have convenient and immediate access to the contents of residents #004, #003, #001 and #006's plan of care, and the 76 other residents related to the sling size to be used for their transfers. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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; and that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

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 #004, #001 and #006.

The MLTC received a CIS report related to a fall resident #004 sustained on an identified date in 2019. The CIS report documented that resident #004 fell from the sling of a TML while being transferred by PSWs #122 and #123. A specified side of the sling holding one area of the resident's body slipped off the TML, which resulted in the resident's fall onto the floor. The resident was transferred to hospital and returned to the home the following day, diagnosed with identified injuries from the fall.

A review of the progress notes in point click care (PCC) documented that upon resident #004's return to the home, they complained of pain to a specified area of the body which had areas of altered skin integrity. The resident was diagnosed with an identified condition to the specified area and started on an identified treatment three days after their return from hospital. On the following day, the resident was transferred to hospital for further assessment of the identified condition as it was not improving and the

resident’s pain increased. The resident returned to the home six days later.

A review of the hospital's discharge notes from the second admission to hospital, documented that resident #004 was treated for the identified condition and had a complex area of altered skin integrity post fall.

In an interview, resident #004 indicated after the fall, they get nervous when they were transferred as they were scared of falling out of the TML again.

A) In an interview, KN #111 stated that the home conducted an investigation of the fall. The TML that was used in the transfer of resident #004 was an identified TML. KN #111 indicated that the sling that was used in the transfer had four ends with three loops at each end. The PSWs were to attach one of the loops at each of the four ends of the sling onto the carry bar of the lift, however, it was discovered through the investigation that PSWs #122 and #123 attached all the three loops of the sling onto the carry bar which became bunched up and difficult to visualize that the loop wasn't attached properly. The loops of the sling were bunched up and not attached properly to the lift, so when PSWs #122 and #123 lifted resident #004 from their mobility device, the sling slipped off the lift and the resident fell.

In an interview, PSW #123 stated that while they were transferring resident #004 with the identified TML, one side of the sling came off the lift and the resident fell to the floor. PSW #123 indicated that they had attached all three loops at each of the four ends of the sling onto the carry bar of the lift. They told the inspector that the identified TML was a new lift in the home for the past year; and they had received training on how to use it.

A review of the home’s investigation notes regarding the fall, documented the identified TML that was used in resident #004’s transfer. The home removed the identified TML from service and had a technician from the vendor conduct a safety inspection. The safety inspection found no problems, and documented that more training was needed. PSWs #122 and #123, who were involved in the fall of resident #004 received training on the identified TML by the vendor on an identified date. In addition, the vendor provided a training review of the identified TML on an identified date in 2019, to KN #111, NC #102, one registered staff and seven PSWs.

In an interview, KN #111 indicated that the home trialled the identified TML in 2018, and decided to keep the TML in 2019. They indicated that the home provided training on the use of the identified TML when it was trialled and again in 2019. They provided the

inspector with the training records.

A review of the training records indicated that on an identified date in 2018, trial training for the identified TML was conducted. Nine PSWs and four registered staff were trained. On an identified date a year later in 2019, new lift training was conducted on the identified TML by KN #111. There were four PSWs who received the training. A further review of the training records indicated that PSW #122 had not received training.

In an interview, AGM #106 confirmed that the home did not have further training records for the identified TML. They reviewed the 2019 training records for the identified TML, and indicated that all direct care staff should have received the training, but did not.

A review of the home's 2018's transfer and lift training for direct care staff (PSWs and registered staff) indicated that 100% of the staff were not trained.

In an interview, IDNC #100 indicated that resident #004 had a significant change in status after their fall. The resident sustained identified injuries and complained of pain. The IDNC indicated that when new equipment is introduced for resident care, all direct care staff (PSWs and registered staff) should be trained. It was also expected that 100% of the direct care staff should have received training on lifts and transfers. They acknowledged that 100% of the direct care staff did not receive training on the identified TML, and the home's transfer and lift training for 2018. The inspector reviewed the home's investigation and interviews with KN #111 and PSW #123 with the IDNC, the IDNC confirmed that PSWs #122 and #123 did not attach the sling properly onto the identified TML which resulted in resident #004's fall with injuries.

B) During a transfer observation conducted by Inspector #665 on an identified date and time, PSWs #109 and #110 transferred resident #004 from an identified mobility device to bed, using a TML. The inspector observed that one of the mobility device's two identified safety mechanism was locked prior to the PSWs lifting the resident. As the resident was being lifted up from their mobility device, it was observed that the mobility device started to move forward with the resident during the transfer. PSW #110 unlocked the identified safety mechanism and moved the mobility device out of the way.

A review of the home's policy titled, Mechanical Lifts, #Tab 04-66A, last reviewed on January 23, 2019, documented under procedure:
-Number six - Ensure the identified safety mechanisms have been applied to the identified mobility device.

In an interview, PSW #109 stated it was the home's policy for the identified mobility device's safety mechanisms be locked prior to transferring any resident. This was to ensure safety of the residents. The PSW indicated that they did not check if the safety mechanisms were locked prior to resident #004's transfer. They further stated it was their responsibility as well as PSW #110 to ensure the safety mechanisms were locked to ensure the safe transfer of resident #004.

In an interview, PSW #110 confirmed they only locked one of the safety mechanisms of the resident's mobility device, in order for them to move the mobility device out of the way during the transfer. PSW #110 indicated their understanding was that it was the home's policy that it was fine for one of safety mechanism to be locked, when a resident was transferred with a TML from the identified mobility device. The PSW reviewed the home's policy Mechanical Lifts, #Tab 04-66A noted above. After reading the policy, PSW #110 stated that they did not follow the home's policy on lifts and transfers.

In an interview, KN #111 stated that it is the home's transfer and lift policy for the identified mobility device's safety mechanisms to be locked prior to transferring any resident from the device using a TML, to ensure their safety. The KN indicated that PSWs #109 and #110 did not use safe transferring techniques when they transferred resident #004.

In an interview, IDNC #100, indicated it was the home's policy for both of the safety mechanisms to be locked on the identified mobility device prior to transferring a resident, to ensure safety of the resident. The IDNC stated that PSWs #109 and #110 did not use proper transferring techniques when they transferred resident #004, as both safety mechanisms were not locked prior to the transfer.

This non compliance is issued as PSWs #122, #123, #109 and #110 failed to use safe transferring and positioning devices or techniques when assisting resident #004. [s. 36.]

2. The MLTC received a CIS report on an identified date in 2019, for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report documented that the resident had three falls in the past three months.

A review of resident #001's current transfer assessment by KN #111 documented the resident required a TML for transfers with a specified sling size.

A review of the resident's current plan of care indicated that the resident was to be transferred by a TML with a specified sling size.

During a transfer observation conducted on an identified date and time in December, 2019, PSWs #107 and #115 transferred resident #001 from their mobility device to bed, using a TML.The sling used for the transfer was a different size from the specified size in the resident's plan of care and transfer assessment.

In separate interviews, PSWs #107 and #115 indicated that the size of the sling to be used with a TML was located in resident #001's kardex in POC. Both PSWs reviewed the resident's kardex and stated the specified sling size was to be used for transfers. The PSWs confirmed that a different sized sling was used in the resident's transfer during the observation by the inspector. PSW #115 stated that they had assisted their co-workers with resident #001's transfers whenever they worked in the resident home area and had not used the sling size specified in the plan of care.

In the interview, PSW #107 indicated that they were the full-time PSW for resident #001 and had been using the different sized sling for one week. PSW #107 stated that the sling used provided more room for the transfer. They indicated it was the home's process to notify the registered staff if they had concerns with the sling so that it can be re-assessed. The PSW stated they did not notify any registered staff and the kinesiologist to have the sling re-assessed for resident #001. PSWs #107 and #115 indicated they used the incorrect size sling for resident #001. PSW #115 further stated that there was a risk of injury to resident #001 when the incorrect sling size was used.

In an interview, IDNC #100 indicated it was the home's expectation for the correct sling to be used based on the transfer assessment by the kinesiologist, to ensure safety of the resident during a transfer with a mechanical lift. They stated that it was an expectation for PSW staff to notify the registered staff if they felt that the sling size required a re-assessment, so that a transfer assessment can be conducted by the kinesiologist. The IDNC indicated that PSWs #107 and #115, did not use safe transferring techniques and devices during the transfer of resident #001.

This non compliance is issued as PSWs #107 and #115 failed to use safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

3. The MLTC received a CIS report on an identified date in 2019, related to an allegation

of staff to resident abuse towards resident #006. The CIS report documented that during an identified shift and time, PSWs #126 and #127 toileted the resident with an identified TML, and an identified area of the body was not placed on the lift properly. The resident indicated the identified area of their body was twisted, and PSW #127 did not fix the identified area when requested by the resident. The resident complained of severe pain to the identified area upon assessment by RN #101.

A review of the transfer assessment conducted by KN #111, prior to the critical incident (CI) indicated that the resident was to be transferred with the identified TML, with a specified sling size.

A review of the resident's written plan of care at the time of the CI and revised by KN #111, directed staff to use the the identified TML for transfers.

In an interview, PSW #126 stated they assisted PSW #127 to transfer resident #006 with the identified TML.The resident was being transferred from their bed to the toilet. When they were lifting the resident up from the bed onto the TML, the resident complained the identified area of their body was not comfortable. PSW #126 told PSW #127 that the identified area was twisted on the lift, but they continued to take the resident to the toilet. In the interview, PSW #126 stated the resident's identified area was not adjusted when resident #006 complained it was not comfortable. The resident continued to complain of the identified area being twisted during the transfer to the toilet, looked uncomfortable and complained of pain. The resident requested the nurse after they were toileted.

PSW #127 continued to work in the home, but was unavailable when attempts were made to contact them, at the time of the inspection.

In an interview, RN #101 stated that PSW #127 requested that they assess resident #006. Upon assessment, the RN indicated that the resident voiced concerns that the identified area was twisted by PSW #127, which caused pain when they were transferred to the toilet. Pain medication was administered after the assessment. The RN stated that they followed up with PSWs #126 and #127 and was told by both PSWs that resident #006 complained of pain to the the identified area when they lifted them onto TML, but it was too late to adjust the identified area at the time.

A record review of the incident report completed by RN #101 documented that the resident informed the RN that when they were transferred to the toilet with the TML, their identified area of the body was twisted and was not adjusted. The resident complained of

severe pain to the area. Pain medication and an identified treatment was administered to resident #006.

A review of the home's investigation notes indicated that PSW #127 was interviewed by IDNC #100. In the interview, PSW #127 stated that resident #006 complained of pain to the identified area that was twisted when they were lifting the resident up from the bed to the TML. PSW #127 indicated that when a resident was being moved and verbalized complaints of pain, they should have stopped moving the resident. The PSW told IDNC #100 that they should not have moved resident #006 when they complained of pain.

A further review of the investigation notes indicated that PSW #127 was disciplined for improper/unsafe transfer which resulted in injury to the resident, and violated the home's lift and transfer policy.

In an interview, IDNC #100 indicated that the home disciplined PSW #127 for unsafe transfer of resident #006. The IDNC stated that PSW #127 also received lift and transfer education after the incident.

The non compliance is issued as PSWs #126 and #127 failed to ensure they used safe transferring and positioning devices or techniques when assisting resident #006. [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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that results of the neglect investigation was reported to the Director.

The home submitted a CIS report for an allegation of neglect towards resident #006 by PSWs #128 and #129 that occurred in 2019.

A review of the CIS report did not have the results of the neglect investigation. The inspector requested documentation of the investigation, but the home was not able to provide any documentation of the investigation that was conducted.

In an interview, AGM #106 indicated that an investigation was conducted by the home but was unable to provide the documentation at the time of the inspection. The AGM confirmed that the results of the investigation was not documented in the CIS report and therefore, not reported to the Director. [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.

Issued on this 19th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JOY IERACI (665)
Inspection No. / No de l’inspection :	2019_641665_0024
Log No. / No de registre :	016077-19, 017364-19, 017513-19, 018068-19, 022361-19, 023140-19, 023458-19, 023491-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 10, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Pauline Dell'Oso

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee must be compliant with s.6(7) of the LTCHA,

Specifically the licensee must:

1) Ensure that all residents who are at high risk for falls are provided with falls prevention and management interventions including the specified intervention as per their plan of care.

2) Develop and implement an auditing tool to ensure that staff are providing care to residents as set out in the plan of care related to fall prevention and management interventions, including the specified intervention.

3) Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member(s) audited, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns and an evaluation of the results.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

The MLTC received a CIS report for a fall resident #005 had on an identified date in 2019. The CIS report indicated that the resident was found lying on the floor in the hallway in front of their bedroom at an identified time, and was assessed by RPN #108. Few hours later, RN #105 observed the resident rubbing a specified area of their body and complaining of pain, and injury was observed. The resident was transferred to hospital to treat an identified injury.

At the time of the inspection, the resident was no longer in the home.

A review of the resident's plan of care documented that the resident was at risk for falls for non-compliance with mobility aide use, health condition and a history of falls prior to admission. The plan of care directed staff to ensure a specified fall intervention was in place to prevent risk of injury from potential falls.

A fall risk assessment was completed two and a half months prior to the resident's fall indicating that the resident was at an identified risk for falls.

In an interview, PSW #125 confirmed that they were the assigned full time PSW for resident #005 at the time of the resident's fall. The PSW stated that they did not implement the specified fall intervention when they provided personal care to the resident prior to the resident's fall. The PSW reviewed the written plan of care and acknowledged that the resident was to have the specified intervention implemented.

In separate interviews, RPN #108 indicated that the resident was a risk for falls. On the day of the fall, they found the resident outside their bedroom door. The RPN indicated they assessed the resident after the fall and the resident was able to stand up, but complained of pain. Two to three hours later, the resident was seen rubbing a specified area of their body and found to have injury; they were then transferred to hospital. RPN #108 indicated initially that the resident had the specified intervention in place when they assessed the resident right after the fall, however, the RPN stated that if they did not document the specified intervention in the falls incident report, then the specified intervention was not implemented at the time of the fall. The inspector informed the RPN that the falls incident report, did not include documentation regarding the specified intervention. The RPN stated, since they did not document the specified intervention in the falls incident report it was not implemented at the time of resident #005's fall.

A review of the falls incident report, by RPN #108 did not include documentation about the resident's specified intervention.

In an interview, IDNC #100 indicated that resident #005 ambulated with a specified mobility device at the time of their fall. The IDNC reviewed the

resident's plan of care and stated that the resident was to have the specified intervention to reduce resident #005's injury from falls. As a result of the fall, the IDNC indicated that the resident had a significant change in health status as the resident sustained an identified injury. The IDNC acknowledged that PSW #125 did not follow the plan of care for resident #005.

This non-compliance is issued since PSW #125 failed to follow the plan of care for resident #005.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #005. The scope of the issue was a level 1 as it was isolated to the residents reviewed. The home had a level 3 compliance history as they had a previous non compliance to the same subsection of the LTCHA that included:
- VPC issued June 20, 2017, (2017_637500_0007).
- CO issued June 5, 2018, (2018_484646_0004).
- VPC issued September 5, 2018, (2018_526645_0010).
- Compliance Order (CO) issued January 31, 2019, (2019_705109_0001).
- Voluntary plan of correction (VPC) issued October 2, 2019, (2019_641665_0016).
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

The licensee must be compliant with O.Reg. 79/10, s. 36 of the LTCHA.

Specifically the licensee must:

1. Ensure that staff use safe transferring and positioning techniques to assist residents #001, #004, #006 and all other residents who require assistance with transferring with a mechanical lift.

2. Ensure all registered staff and personal support workers (PSWs) receive training/re-training on safe use of all mechanical lifts used in the home including the identified total mechanical lift (TML), and safe transferring and positioning of residents.

3. Develop and implement an auditing tool to ensure that staff are assisting residents with transferring using safe transferring devices and techniques including use of the identified TML, according to the home's written policies.

4. Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #004, #001 and #006.

The MLTC received a CIS report related to a fall resident #004 sustained on an identified date in 2019. The CIS report documented that resident #004 fell from the sling of a TML while being transferred by PSWs #122 and #123. A specified side of the sling holding one area of the resident's body slipped off the TML, which resulted in the resident's fall onto the floor. The resident was transferred to hospital and returned to the home the following day, diagnosed with identified injuries from the fall.

A review of the progress notes in point click care (PCC) documented that upon resident #004's return to the home, they complained of pain to a specified area of the body which had areas of altered skin integrity. The resident was diagnosed with an identified condition to the specified area and started on an identified treatment three days after their return from hospital. On the following day, the resident was transferred to hospital for further assessment of the identified condition as it was not improving and the resident's pain increased. The resident returned to the home six days later.

A review of the hospital's discharge notes from the second admission to hospital, documented that resident #004 was treated for the identified condition and had a complex area of altered skin integrity post fall.

In an interview, resident #004 indicated after the fall, they get nervous when they were transferred as they were scared of falling out of the TML again.

A) In an interview, KN #111 stated that the home conducted an investigation of the fall. The TML that was used in the transfer of resident #004 was an identified TML. KN #111 indicated that the sling that was used in the transfer had four ends with three loops at each end. The PSWs were to attach one of the loops at each of the four ends of the sling onto the carry bar of the lift, however, it was discovered through the investigation that PSWs #122 and #123 attached all the three loops of the sling onto the carry bar which became bunched up and difficult to visualize that the loop wasn't attached properly. The loops of the sling were bunched up and not attached properly to the lift, so when PSWs #122 and #123 lifted resident #004 from their mobility device, the sling slipped off the lift and the resident fell.

In an interview, PSW #123 stated that while they were transferring resident #004

with the identified TML, one side of the sling came off the lift and the resident fell to the floor. PSW #123 indicated that they had attached all three loops at each of the four ends of the sling onto the carry bar of the lift. They told the inspector that the identified TML was a new lift in the home for the past year; and they had received training on how to use it.

A review of the home's investigation notes regarding the fall, documented the identified TML that was used in resident #004's transfer. The home removed the identified TML from service and had a technician from the vendor conduct a safety inspection. The safety inspection found no problems, and documented that more training was needed. PSWs #122 and #123, who were involved in the fall of resident #004 received training on the identified TML by the vendor on an identified date. In addition, the vendor provided a training review of the identified TML on an identified date in 2019, to KN #111, NC #102, one registered staff and seven PSWs.

In an interview, KN #111 indicated that the home trialled the identified TML in 2018, and decided to keep the TML in 2019. They indicated that the home provided training on the use of the identified TML when it was trialled and again in 2019. They provided the inspector with the training records.

A review of the training records indicated that on an identified date in 2018, trial training for the identified TML was conducted. Nine PSWs and four registered staff were trained. On an identified date a year later in 2019, new lift training was conducted on the identified TML by KN #111. There were four PSWs who received the training. A further review of the training records indicated that PSW #122 had not received training.

In an interview, AGM #106 confirmed that the home did not have further training records for the identified TML. They reviewed the 2019 training records for the identified TML, and indicated that all direct care staff should have received the training, but did not.

A review of the home's 2018's transfer and lift training for direct care staff (PSWs and registered staff) indicated that 100% of the staff were not trained.

In an interview, IDNC #100 indicated that resident #004 had a significant change

in status after their fall. The resident sustained identified injuries and complained of pain. The IDNC indicated that when new equipment is introduced for resident care, all direct care staff (PSWs and registered staff) should be trained. It was also expected that 100% of the direct care staff should have received training on lifts and transfers. They acknowledged that 100% of the direct care staff did not receive training on the identified TML, and the home's transfer and lift training for 2018. The inspector reviewed the home's investigation and interviews with KN #111 and PSW #123 with the IDNC, the IDNC confirmed that PSWs #122 and #123 did not attach the sling properly onto the identified TML which resulted in resident #004's fall with injuries.

B) During a transfer observation conducted by Inspector #665 on an identified date and time, PSWs #109 and #110 transferred resident #004 from an identified mobility device to bed, using a TML. The inspector observed that one of the mobility device's two identified safety mechanism was locked prior to the PSWs lifting the resident. As the resident was being lifted up from their mobility device, it was observed that the mobility device started to move forward with the resident during the transfer. PSW #110 unlocked the identified safety mechanism and moved the mobility device out of the way.

A review of the home's policy titled, Mechanical Lifts, #Tab 04-66A, last reviewed on January 23, 2019, documented under procedure:
-Number six - Ensure the identified safety mechanisms have been applied to the identified mobility device.

In an interview, PSW #109 stated it was the home's policy for the identified mobility device's safety mechanisms be locked prior to transferring any resident. This was to ensure safety of the residents. The PSW indicated that they did not check if the safety mechanisms were locked prior to resident #004's transfer. They further stated it was their responsibility as well as PSW #110 to ensure the safety mechanisms were locked to ensure the safe transfer of resident #004.

In an interview, PSW #110 confirmed they only locked one of the safety mechanisms of the resident's mobility device, in order for them to move the mobility device out of the way during the transfer. PSW #110 indicated their understanding was that it was the home's policy that it was fine for one of safety mechanism to be locked, when a resident was transferred with a TML from the

identified mobility device. The PSW reviewed the home's policy Mechanical Lifts, #Tab 04-66A noted above. After reading the policy, PSW #110 stated that they did not follow the home's policy on lifts and transfers.

In an interview, KN #111 stated that it is the home's transfer and lift policy for the identified mobility device's safety mechanisms to be locked prior to transferring any resident from the device using a TML, to ensure their safety. The KN indicated that PSWs #109 and #110 did not use safe transferring techniques when they transferred resident #004.

In an interview, IDNC #100, indicated it was the home's policy for both of the safety mechanisms to be locked on the identified mobility device prior to transferring a resident, to ensure safety of the resident. The IDNC stated that PSWs #109 and #110 did not use proper transferring techniques when they transferred resident #004, as both safety mechanisms were not locked prior to the transfer.

This non compliance is issued as PSWs #122, #123, #109 and #110 failed to use safe transferring and positioning devices or techniques when assisting resident #004.
(665)

2. The MLTC received a CIS report on an identified date in 2019, for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report documented that the resident had three falls in the past three months.

A review of resident #001's current transfer assessment by KN #111 documented the resident required a TML for transfers with a specified sling size.

A review of the resident's current plan of care indicated that the resident was to be transferred by a TML with a specified sling size.

During a transfer observation conducted on an identified date and time in December, 2019, PSWs #107 and #115 transferred resident #001 from their

mobility device to bed, using a TML.The sling used for the transfer was a different size from the specified size in the resident's plan of care and transfer assessment.

In separate interviews, PSWs #107 and #115 indicated that the size of the sling to be used with a TML was located in resident #001's kardex in POC. Both PSWs reviewed the resident's kardex and stated the specified sling size was to be used for transfers. The PSWs confirmed that a different sized sling was used in the resident's transfer during the observation by the inspector. PSW #115 stated that they had assisted their co-workers with resident #001's transfers whenever they worked in the resident home area and had not used the sling size specified in the plan of care.

In the interview, PSW #107 indicated that they were the full-time PSW for resident #001 and had been using the different sized sling for one week. PSW #107 stated that the sling used provided more room for the transfer. They indicated it was the home's process to notify the registered staff if they had concerns with the sling so that it can be re-assessed. The PSW stated they did not notify any registered staff and the kinesiologist to have the sling re-assessed for resident #001. PSWs #107 and #115 indicated they used the incorrect size sling for resident #001. PSW #115 further stated that there was a risk of injury to resident #001 when the incorrect sling size was used.

In an interview, IDNC #100 indicated it was the home's expectation for the correct sling to be used based on the transfer assessment by the kinesiologist, to ensure safety of the resident during a transfer with a mechanical lift. They stated that it was an expectation for PSW staff to notify the registered staff if they felt that the sling size required a re-assessment, so that a transfer assessment can be conducted by the kinesiologist. The IDNC indicated that PSWs #107 and #115, did not use safe transferring techniques and devices during the transfer of resident #001.

This non compliance is issued as PSWs #107 and #115 failed to use safe transferring and positioning devices or techniques when assisting resident #001.

(665)

3. The MLTC received a CIS report on an identified date in 2019, related to an allegation of staff to resident abuse towards resident #006. The CIS report documented that during an identified shift and time, PSWs #126 and #127 toileted the resident with an identified TML, and an identified area of the body was not placed on the lift properly. The resident indicated the identified area of their body was twisted, and PSW #127 did not fix the identified area when requested by the resident. The resident complained of severe pain to the identified area upon assessment by RN #101.

A review of the transfer assessment conducted by KN #111, prior to the critical incident (CI) indicated that the resident was to be transferred with the identified TML, with a specified sling size.

A review of the resident's written plan of care at the time of the CI and revised by KN #111, directed staff to use the the identified TML for transfers.

In an interview, PSW #126 stated they assisted PSW #127 to transfer resident #006 with the identified TML.The resident was being transferred from their bed to the toilet. When they were lifting the resident up from the bed onto the TML, the resident complained the identified area of their body was not comfortable. PSW #126 told PSW #127 that the identified area was twisted on the lift, but they continued to take the resident to the toilet. In the interview, PSW #126 stated the resident's identified area was not adjusted when resident #006 complained it was not comfortable. The resident continued to complain of the identified area being twisted during the transfer to the toilet, looked uncomfortable and complained of pain. The resident requested the nurse after they were toileted.

PSW #127 continued to work in the home, but was unavailable when attempts were made to contact them, at the time of the inspection.

In an interview, RN #101 stated that PSW #127 requested that they assess resident #006. Upon assessment, the RN indicated that the resident voiced concerns that the identified area was twisted by PSW #127, which caused pain when they were transferred to the toilet. Pain medication was administered after the assessment. The RN stated that they followed up with PSWs #126 and #127 and was told by both PSWs that resident #006 complained of pain to the

the identified area when they lifted them onto TML, but it was too late to adjust the identified area at the time.

A record review of the incident report completed by RN #101 documented that the resident informed the RN that when they were transferred to the toilet with the TML, their identified area of the body was twisted and was not adjusted. The resident complained of severe pain to the area. Pain medication and an identified treatment was administered to resident #006.

A review of the home's investigation notes indicated that PSW #127 was interviewed by IDNC #100. In the interview, PSW #127 stated that resident #006 complained of pain to the identified area that was twisted when they were lifting the resident up from the bed to the TML. PSW #127 indicated that when a resident was being moved and verbalized complaints of pain, they should have stopped moving the resident. The PSW told IDNC #100 that they should not have moved resident #006 when they complained of pain.

A further review of the investigation notes indicated that PSW #127 was disciplined for improper/unsafe transfer which resulted in injury to the resident, and violated the home's lift and transfer policy.

In an interview, IDNC #100 indicated that the home disciplined PSW #127 for unsafe transfer of resident #006. The IDNC stated that PSW #127 also received lift and transfer education after the incident.

The non compliance is issued as PSWs #126 and #127 failed to ensure they used safe transferring and positioning devices or techniques when assisting resident #006.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #004. The scope of the issue was a level 3 as it is related to three out of four residents reviewed. The home had a level 3 compliance history as they had a previous non compliance to the same subsection of the LTCHA that included:
- Compliance Order (CO) issued June 5, 2018, (2018_484646_0004). (665)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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