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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 31, 2017 | 2017_634512_0007 | 003635-15, 006880-15, 027959-15, 031430-15, 020420-16, 026493-16, 032962-16, 002219-17 | Critical Incident System |

### Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street TORONTO ON M5T 1J7

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

MON SHEONG SCARBOROUGH LONG TERM CARE CENTRE
2030 Mcnicoll Avenue SCARBOROUGH ON M1V 5P4

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

TILDA HUI (512), JULIENNE NGONLOGA (502)

### 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): March 2, 3, 7, 8, 9. 10, 13, 14, 15 and 16, 2017.**

**This inspection was conducted related to the following intakes: #010792-15, #014313-16, and #026493-16 related to falls resulting in fatal injuries; #006880-15, #000897-17, and #002219-17 related to abuse; #020420-16 related to nutrition and hydration.**

**The following intakes related to falls resulting in non-fatal injuries were not inspected at this inspection: #003635-15, #027959-15, and #032962-16.**

**This inspection was conducted concurrently with inspections 2017_626501-0007, 2017_626501-0008, 2017_626501-0009 and 2017_626501-0010. A Compliance Order (CO) under O.Reg.79/10 s. 8(1)(b) identified in inspection 2017_626501-0010 will be issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Director of Resident Care (DORC), Food Service Supervisor (FSS), Registered Dietitian (RD), Physiotherapist (PT), Attending Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide (DA), Resident, Family Members and Substitute Decision Makers.**

**During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including toileting and meal delivery services, and review of the home's staff training records, staff schedules, staff personal records, incidents investigation records, meeting minutes, relevant policies and procedures, and residents' health records.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Falls Prevention**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 failed to ensure that residents are protected from abuse by anyone.

On an identified date a Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to alleged abuse during the provision of care.

Review of the anonymous letter revealed on an identified date, staff #119 was observed threatening resident #004 and shortly after the staff carried out his/her threat toward the resident.

Review of resident #004's written plan of care with an identified date, revealed resident #004 was totally dependent and required extensive assistance of one staff. Further review of resident #004's written plan of care directed staff to use gentle approach if resident #004 resisted care.

The viewing of the video footage recorded on the identified date and review of the summary notes of the home's investigation revealed inappropriate staff behaviour toward resident #004 during the provision of care, which posed potential injury to the resident and resulted in pain to resident #004.

In an interview staff #119 stated resident #004 had been resistive to care. He/she had denied any wrong doing during the provision of care and believed action taken against him/her was unjust. In an interview, the Administrator confirmed that the abuse occurred.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 19. (1)]

2. The licensee has failed to ensure that resident #001 was protected from neglect by the staff in the home.

On identified date a CIS report was submitted to the MOHLTC related to a fall. Review of the home's investigation notes indicated on an identified date and time resident #001 was physically restrained and was left unattended during care for an extended period of time, and was found unresponsive. Further review of the home investigation revealed that staff #110 and #111 told staff #129 and #130 that resident #001 had a fall during a specified care. During the home's investigation, the DORC was told by staff that the resident was left improperly restrained to a specified piece of equipment for two hours unattended prior to the resident being found on the floor unresponsive. The DORC

submitted a revised CI report #2944-000004-17 with the category of the incident as abuse/neglect to the MOHLTC on February 2, 2017, at 2304 hours. The home issued disciplinary actions to staff #129, #130, #111, #118 and #131 after the investigation was concluded.

Observation made during the inspection revealed the incident happened in a home area near the nursing station.

Interviews with staff #111 stated that on identified date and time, he/she physically restrained resident #001 during the provision of a specified care with the assistance of staff #131, as resident #001 had identified responsive behaviours. Staff #111 stated that he/she endorsed the care to staff #118 and went to assist other residents. Staff #111 also stated it was a common practice on the unit to restrain the resident in this manner for a long period of time.

Interview with staff #118 indicated he/she was very busy on the day shift on the identified date that he/she had forgotten about resident #001. Staff #118 admitted he/she neglected to check on the resident which he/she should have done. PSW #118 stated after the resident was discovered, he/she provided assistance.

In an interview staff #110 stated that on the date of incident, staff #118 asked him/her to check on resident #001 as he/she had other tasks to perform. Staff #110 stated he/she observed that resident #001 had a fall with injury and called staff #118 and #129 for assistance.

Interview with staff #101 and #109 revealed the PSWs told him/her that the resident had a fall while care was being provided.

Interview with staff #130 indicated he/she was not on duty at the time of the incident, however, he/she stated being aware that staff had been using transfer device to provide specified care which the resident was not assessed as requiring the use. Staff #130 stated he/she had previously reminded the staff not to use the identified device during care, as it was not indicated in the care plan. However he/she did not follow up and monitored the staff for their compliance of his/her direction.

Review of the resident's written plan of care with an identified date, revealed the resident was assessed to have cognitive impairment, was resistive to care at times, was at risk of falls and had responsive behavior. There was no indication that the resident required

transfer device for the specified care.

Interviews with staff #111, #118, #101, #129, and #130, stated resident #001 was neglected by the home's staff while care was being provided. Interviews with staff #109, #112, the DORC and the Senior Administrator confirmed that there was neglect to the resident while the specified care was being provided.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance issued to the home in the last three years. Based upon this information, 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".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the home's fall management policy is complied with.

A CIS report was submitted to MOHLTC in relation to resident #002's unwitnessed fall on an identified date and time in a specified home area. Review of the CI report indicated the resident was found by staff #127 on the floor and he/she sustained injury.

Review of the home's policy titled Fall prevention and Management Program, policy number R.C ±4.7, revision date July 2016, section B, under Post Fall Assessment and Management, item #2 stated: Do not move the resident, even though there is no apparent injury noticed, until a full head-to-toe assessment has been conducted.

Review of the resident's progress notes revealed at time of incident, staff #127 was providing care to another resident in a nearby room and heard a loud bang coming from resident #002's room. The resident's room door was closed and staff #127 opened the door and found the resident had fallen outside the specified area.

Interview with staff #127 stated that he/she assisted the resident back to bed. Staff #127 verbalized he/she was aware that according to the home's policy, resident must not be moved after an unwitnessed fall until assessed by a Registered Nurse.

Interview with staff #128 indicated when he/she arrived to the resident's room, the resident was already in his/her bed. Staff #128, #109 and #124 indicated resident found after an unwitnessed fall was not to be moved until a full assessment was conducted by the registered staff.

Interview with the DORC confirmed that the home's policy of fall management was not complied with by staff #127. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CIS report was submitted to the MOHLTC related to resident #006's unwitnessed fall on an identified date.

Review of the home's policy #RC-4.7 titled Fall Prevention and Management Program revised July 2016, states that part of the post fall assessment and management involves the initiation of a specified assessment for a suspected condition.

The following evidence related to resident #006 collected during complaint inspection #2017_626501_0010, conducted on March 10, 2017, is captured with this finding of noncompliance in this report.

Record review revealed on an identified date, resident #006 had a fall and there was no evidence that a specified assessment was completed.

Interview with the DORC revealed that it is the home's protocol that registered staff

assess the resident and decide whether to initiate the specified assessment. However, in the above mentioned incident, the registered staff should have documented why he/she did not initiate the specified assessment. Interview with the Administrator confirmed that in this case the home did not follow their policy.

Record review also revealed resident #006 had an unwitnessed fall on an identified date, a potential specified injury was suspected. A specified assessment tool was initiated at the same time, for resident #006 but was only partially filled in. Interview with the Administrator confirmed the registered staff had not completed the chart according to the home's policy and the staff were re-educated shortly after the home investigated the incident. [s. 8. (1) (a),s. 8. (1) (b)]

3. A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device during the provision of care and was found two hours later unresponsive. Review of the home's policy titled Fall Prevention and Management Program, policy number R.C. - 4.7 with revision date of July 2016, under section B, Post Fall Assessment and Management, item #2 stated: do not move the resident, even though there is no apparent injury notice, until a full head to toe assessment has been conducted.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of staff #131. They used a transfer device to restraint the resident and he/she was left unattended. Staff #111 stated 45 minutes after, he/she had told assigned staff #118 that the resident was still in the specified location. Staff #111 then went on to assist with other residents on his/her own assignment.

Interview with staff #118 indicated he/she was very busy on the identified shift when the incident occurred, so that he/she had forgotten what staff #111 had told him/her about resident #001. Staff #118 admitted he/she neglected to check on the resident which he/she should have done. After the resident was discovered he/she assisted to release the resident from the restraint. Staff #118 stated he/she was frightened and did not know what to do. He/she could not recall who had given the instruction to transfer the resident back to the room. Staff #118 verbalized understanding of the home's policy not to move the resident after an unwitnessed fall until a full head to toe assessment has been conducted.

Interview with staff #110 stated after becoming aware of the incident he/she rushed to the nursing station, called staff #129 and #118. All staff assisted in releasing the resident from the restraint, could not recall who gave the suggestion to move the resident onto the wheelchair and transported back to his/her own bed. Interview with staff #101 stated the resident was already in bed unresponsive when he/she arrived.

Interviews with staff #111, #118, and #129, indicated after an unwitnessed fall, resident #001 was moved from the floor to a wheelchair and then was transferred back to his/her own bed before a full head to toe assessment by the registered nursing staff was completed. Interviews with staff #109, #112, and the DORC confirmed that the home's policy on fall prevention and management of not moving the resident after an unwitnessed fall was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee has failed to ensure that the home`s policy on continence care and bowel management put in place is complied with.

The home's policy titled Continence Care and Bowel Management Program policy number RC-4.6.2 with revision date of July 2016 was reviewed. Under the Procedure section, item #4 stated that any resident requiring support in a sitting position must not be left unattended. Under same section, item #10 stated that under no circumstances shall resident be restrained while using specified equipment.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device during the provision of care and was found two hours later unresponsive.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of staff #131. They used a transfer device to restraint the resident to prevent him/her of exhibiting an identified responsive behaviour. Staff #111 stated that using the transfer device to restraint the resident during care was a common practice on the unit for long period of time from 20 minutes to sometimes over an hour.

Interview with staff #118 indicated similar rationale for using the transfer device during resident #001's specified care. Staff #118 stated he/she was very busy on the day shift of

the identified date, that he/she had forgotten what staff #111 had told him/her about resident #001 still in a specified location. Staff #118 admitted he/she was neglectful to check on the resident which she should have done.

Review of the resident's written plan of care with an identified date, revealed the resident was cognitively impaired, had a specified medical condition, and exhibited specified responsive behaviour. The resident was described as frequently incontinent of bladder function, required scheduled toileting and the use of incontinent products. There was no indication that a transfer device was to be used on the resident when providing the specified care.

Interviews with staff #111, #118, #101, #129, and #130, indicated a transfer device had been used on resident #001 for months before the incident. Interviews with the DORC who was the lead of the continence program confirmed that staff #111 and #118 did not comply with the home's policy on not leaving resident who required support in a sitting position unattended and restraining resident while providing the specified care.

The severity of these incidents is actual harm as the residents had sustained injury. The scope of these incidents is isolated to the above mentioned two residents. There is ongoing non-compliance to a voluntary plan of correction (VPC) issued in similar area to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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

**Findings/Faits saillants :**

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

A CIS report was submitted to MOHLTC in relation to resident #002's unwitnessed fall on an identified date and time in a specified home area.

Review of the CI report indicated the resident was found by staff #127 on the floor and he/she sustained injury. Staff #127 assisted the resident to his/her bed and then called the registered nursing staff on duty. Resident was found to be unresponsive thereafter. The CI report was submitted to MOH on same day at 1538 hours.

Review of the resident's progress notes revealed resident #002 had three falls within four months since admission. The resident had unwitnessed fall at approximately one and two months after admission with no injury. The third fall occurred on about three and half months after admission which the resident complained of pain.

Review of the Physiotherapy (PT) notes revealed that after the second fall, the resident was identified as having difficulty using brakes of rollator properly and always forgot to use the brakes. The resident was also identified to be not wearing shoes properly. Staff #126 advised resident to wear sandals or shoes with good traction and wide base.

Review of the resident's written plan of care revised after the second fall, did not include the monitoring of the resident's use of the rollator brakes and the resident's footwear use to ensure safety.

Interview with PT #126 indicated the PT had made the above mentioned observations and documented in the progress notes. The PT could recall communicating the footwear observation to the nursing staff however was not sure about the rollator brakes issue. Staff #128 stated not aware of the PT's observation. Staff #128 further stated if he/she was aware of the observations and recommendation, he/she would have included them in the resident's written plan of care and set up related interventions to prevent falls.

Interview with the DORC confirmed that resident #002's written plan of care did not set out clear directions to staff who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device during the provision of care and was found two hours later unresponsive.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of PSW #131. They used a transfer device to restraint the resident to prevent him/her of exhibiting an identified responsive behaviour. PSW #111 stated that using the transfer device to restraint the resident during care was a common practice on the unit for long period of time from 20 minutes to sometimes over an hour.

Interview with Staff #118 stated he/she was very busy on the day shift of an identified date, that he/she had forgotten what staff #111 had told him/her about resident #001 still in a specified location. Staff #118 admitted he/she was neglectful to check on the resident which she should have done. Staff #118 also indicated he/she did not review the resident written plan of care prior to providing care to the resident, and did not inform the registered nursing staff on the unit that the resident was requiring the transfer device. Staff #111 and #131 in interviews stated they did not read resident #001s written plan of care before providing care for the resident, and they had neglected to inform the

registered nursing staff on duty that the PSWs were using the transfer device when providing the specified care to the resident.

Interview with staff #130 indicated he/she was not on duty at the time of the incident, but was aware that the PSWs had been providing the specified care with an identified transfer device the resident was not assessed as requiring during care. Staff #130 stated once he/she had reminded the PSWs not to use the identified device while providing care to resident #001 as it was not indicated in the care plan. However he/she did not follow up and monitored for the PSWs' compliance of his/her direction.

Review of the resident's written plan of care with an identified date, revealed the resident was cognitively impaired, had a specified medical condition, and exhibited specified responsive behaviour. The resident was described as frequently incontinent of bladder function, required scheduled toileting and the use of incontinent products. There was no indication that a specified transfer device was to be used for the resident.

Interviews with staff #111, #118, #101, #129, and #130, indicated with a specified transfer device had been used on resident #001 for months before the incident. Interview with the DORC who was the lead of the continence program confirmed that resident #001's written plan of care should have been revised to reflect that the resident's continence care need has changed. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that the plan of care set out clear directions to staff and others who provide direct care to the resident, and that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A CI Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to staff-to-resident abuse. The CI report revealed the Director of Resident Care (DORC) received an anonymous letter indicating that an alleged abuse occurred in the home 11 days after the incident.

Review of the anonymous letter revealed on an identified date, staff #119 was observed behaving inappropriately toward resident #004 during the provision of care.
The inspector was not able to interview the DORC as he/she retired a year prior to the inspection.

Interview with the Senior Administrator confirmed that the DORC received the above mentioned letter 11 days after the incident and reported the incident one day after the home became aware of the alleged staff to resident abuse, as he/she was gathering additional information. The Senior Administrator also stated that the DORC was the most senior person in the home responsible to report the incident. [s. 24. (1)]

2. A CIS report was submitted to MOHLTC related to fall during care, in which resident

#001 was found unresponsive.

Review of the home's investigation notes indicated on an identified date and time, resident #001 was left unsupervised and restrained in a transfer device while receiving care. The resident was found unresponsive two hours later. CIS further revealed staff #110 and #111 after finding the resident, they told staff #130 and #129 that resident #001 had fallen during care. The DORC submitted a CI report to the MOHLTC on an identified date. The DORC initiated an investigation and conducted staff interviews, which revealed the resident was left restrained in a transfer device during care for two hours and unattended prior to the resident being found unresponsive. The DORC submitted a revised CI report to the MOHLTC seven days after the home became aware that the incident was a category of abuse/neglect to the resident.

Interviews with staff #109, #112, the DORC and the Senior Administrator confirmed that there was neglect to the resident during the provision of care and the MOHLTC was not reported to immediately after the home was made aware of the neglect to the resident by the home staff during the staff interviews conducted on identified dates. Interview with the DORC confirmed that the revised report of abuse and neglect was not submitted until seven days after. [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 that the person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement**
**For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:**
**1. Roller bars on wheelchairs and commodes or toilets.**
**2. Vest or jacket restraints.**
**3. Any device with locks that can only be released by a separate device, such as a key or magnet.**
**4. Four point extremity restraints.**
**5. Any device used to restrain a resident to a commode or toilet.**
**6. Any device that cannot be immediately released by staff.**
**7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that prohibited devices that limit movement are not used in the home.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device during the provision of care and was found two hours later unresponsive.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of staff #131. They used a transfer device to restraint the resident to prevent him/her of exhibiting an identified responsive behaviour. Staff #111 stated that using the transfer device to restraint the resident during care was a common practice on the unit for long period of time from 20 minutes to sometimes over an hour.

Interview with staff #118 indicated similar rationale for using the transfer device during resident #001's specified care. Staff #118 stated he/she was very busy on the day shift of an identified date, that he/she had forgotten what staff #111 had told him/her about

resident #001 still in a specified location. Staff #118 admitted he/she was neglectful to check on the resident which he/she should have done. Staff #118 also indicated he/she did not review the resident's written plan of care prior to providing care to the resident, and did not inform the registered nursing staff on the unit that the resident was requiring the transfer device for care.

Staff #111 and #118 in interviews stated they did not read resident 001's written plan of care before providing care to the resident, and they had neglected to inform the RPNs on duty that PSWs were using a specified transfer device to provide care to the resident.

Interview with staff #130 indicated he/she was not on duty at the time of the incident. Staff #130 stated that he/she was aware that the staff had been using the identified transfer device to provide specified care to the resident which the resident was not assessed to be using. Staff #130 stated once he/she had reminded the staff not to use the identified transfer device to care for the resident as it was not indicated in the care plan. However he/she did not follow up and monitored the staff compliance of his/her direction.

Review of the resident's written plan of care with an identified date revealed the resident had specified medical condition and exhibit specified responsive behaviour. The resident was described as frequently incontinent of bladder function, required scheduled toileting and use of incontinent products. There was no indication that the resident required a specified transfer device.

Interviews with staff #111, #118, #101, #129, and #130, indicated resident #001 was being cared for with the specified transfer device for months before the incident. Interviews with the DORC confirmed that the home staff had used the specified transfer device to manage resident #001’s behavior by restraining him/her. [s. 112.]

***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 prohibited devices that limit movement are not used in the home, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's continence care and bowel management program included a resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff conducted in 2016.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being

provided with a transfer device.

Review of the home's continence care and bowel management program records failed to reveal any evidence of a continence products survey conducted for 2016.

Interview with the DORC who was the lead of the continence care and bowel management program, indicated the home did not conduct an annual continence products satisfaction survey for 2016. The home had planned to conduct the survey in December 2016 by using volunteers to visit residents with survey questions. The survey was cancelled because of two outbreaks prohibiting volunteers to visit residents in their home areas. [s. 51. (1) 5.]

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

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #002 had an unwitnessed fall with injury in a specified home area and found by staff #127. The staff assisted the resident to his/her bed and then called the registered nursing staff on duty. The resident was found unresponsive.

Review of the resident's continence assessments record for a period of time revealed resident #002 was continent of bladder on admission, a month later he/she became occasional incontinent for and then frequently incontinent two months after. Further review of the continence assessments record failed to reveal evidence of any continent assessment conducted on the resident when the resident's bladder function deteriorated from continent to occasional incontinent, and then to frequently incontinent.

Interview with staff #128 stated the home's staff were supposed to conduct continence assessment by using the template on the home's electronic documentation system for the resident when the resident's continence function changed from continent to incontinent. Staff #128 indicated he/she being part time was aware that there was a deterioration of the resident's bladder function however was not aware that a continence assessment was not conducted on the resident.

Interview with the DORC who was the lead of the continence program, confirmed that a

continence assessment was not conducted when the resident was identified as incontinent. [s. 51. (2) (a)]

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**Issued on this 31st day of July, 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) :** | TILDA HUI (512), JULIENNE NGONLOGA (502) |
| **Inspection No. / No de l'inspection :** | 2017_634512_0007 |
| **Log No. / Registre no:** | 003635-15, 006880-15, 027959-15, 031430-15, 020420-16, 026493-16, 032962-16, 002219-17 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jul 31, 2017 |
| **Licensee / Titulaire de permis :** | MON SHEONG FOUNDATION<br>36 D'Arcy Street, TORONTO, ON, M5T-1J7 |
| **LTC Home / Foyer de SLD :** | MON SHEONG SCARBOROUGH LONG TERM CARE CENTRE<br>2030 Mcnicoll Avenue, SCARBOROUGH, ON, M1V-5P4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | STELLA LEUNG |

To MON SHEONG FOUNDATION, 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 :**

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:

1. Provide training to all staff on the home's policy to promote zero tolerance of abuse and neglect of residents, to ensure all staff are aware and can demonstrate an understanding of all form of abuse as specified within the Long Term Care Homes Act, 2007, Ontario Regulations 79/10.
2. Provide training on feeding techniques to everyone assisting a resident with feeding during meal and snack services.

The plan is to be submitted to juliene.ngonloga@ontario.ca by May 17, 2017.

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #001 was protected from neglect by the staff in the home.

On identified date a CIS report was submitted to the MOHLTC related to a fall. Review of the home's investigation notes indicated on an identified date and time resident #001 was physically restrained and was left unattended during care for an extended period of time, and was found unresponsive. Further review of the home investigation revealed that staff #110 and #111 told staff #129 and #130 that resident #001 had a fall during a specified care.
During the home's investigation, the DORC was told by staff that the resident was left improperly restrained to a specified piece of equipment for two hours unattended prior to the resident being found on the floor unresponsive. The DORC submitted a revised CI report #2944-000004-17 with the category of the

incident as abuse/neglect to the MOHLTC on February 2, 2017, at 2304 hours. The home issued disciplinary actions to staff #129, #130, #111, #118 and #131 after the investigation was concluded.

Observation made during the inspection revealed the incident happened in a home area near the nursing station.

Interviews with staff #111 stated that on identified date and time, he/she physically restrained resident #001 during the provision of a specified care with the assistance of staff #131, as resident #001 had identified responsive behaviours. Staff #111 stated that he/she endorsed the care to staff #118 and went to assist other residents. Staff #111 also stated it was a common practice on the unit to restrain the resident in this manner for a long period of time.

Interview with staff #118 indicated he/she was very busy on the day shift on the identified date that he/she had forgotten about resident #001. Staff #118 admitted he/she neglected to check on the resident which he/she should have done. PSW #118 stated after the resident was discovered, he/she provided assistance.

In an interview staff #110 stated that on the date of incident, staff #118 asked him/her to check on resident #001 as he/she had other tasks to perform. Staff #110 stated he/she observed that resident #001 had a fall with injury and called staff #118 and #129 for assistance.

Interview with staff #101 and #109 revealed the PSWs told him/her that the resident had a fall while care was being provided.

Interview with staff #130 indicated he/she was not on duty at the time of the incident, however, he/she stated being aware that staff had been using transfer device to provide specified care which the resident was not assessed as requiring the use. Staff #130 stated he/she had previously reminded the staff not to use the identified device during care, as it was not indicated in the care plan. However he/she did not follow up and monitored the staff for their compliance of his/her direction.

Review of the resident's written plan of care with an identified date, revealed the resident was assessed to have cognitive impairment, was resistive to care at times, was at risk of falls and had responsive behavior. There was no indication

that the resident required transfer device for the specified care.

Interviews with staff #111, #118, #101, #129, and #130, stated resident #001 was neglected by the home's staff while care was being provided. Interviews with staff #109, #112, the DORC and the Senior Administrator confirmed that there was neglect to the resident while specified care was being provided.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 19. (1)]

(512)

2. The licensee failed to ensure that residents are protected from abuse by anyone.

On an identified date a Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to alleged abuse during the provision of care.

Review of the anonymous letter revealed on an identified date, staff #119 was observed threatening resident #004 and shortly after the staff carried out his/her threat toward the resident.

Review of resident #004's written plan of care with an identified date, revealed resident #004 was totally dependent and required extensive assistance of one staff. Further review of resident #004's written plan of care directed staff to use gentle approach if resident #004 resisted care.

The viewing of the video footage recorded on the identified date and review of the summary notes of the home's investigation revealed inappropriate staff behaviour toward resident #004 during the provision of care, which posed potential injury to the resident and resulted in pain to resident #004.

In an interview staff #119 stated resident #004 had been resistive to care. He/she had denied any wrong doing during the provision of care and believed action taken against him/her was unjust. In an interview, the Administrator

confirmed that the abuse occurred.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 19. (1)] (502)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 04, 2017

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 :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that the home's policies on fall prevention and management and on continence and bowel management instituted are complied with.
The plan shall include, but not limited to the following:

1. Provide training to all direct care staff on the home's policy on fall prevention and management, as well as continence and bowel management.
2. Review of the home's orientation content to include training for the two above mentioned policies.
3. Develop and implement a process to monitor staff's performance in adherence to the home's above mentioned policies

The plan is to be submitted to juliene.ngonloga@ontario.ca by May 17, 2017.

**Grounds / Motifs :**

1. 2. A CIS report was submitted to MOHLTC in relation to resident #002's unwitnessed fall on an identified date and time in a specified home area.

Review of the CI report indicated the resident was found by staff #127 on the floor and he/she sustained injury.

Review of the home's policy titled Fall prevention and Management Program, policy number R.C ±4.7, revision date July 2016, section B, under Post Fall

Assessment and Management, item #2 stated: Do not move the resident, even though there is no apparent injury noticed, until a full head-to-toe assessment has been conducted.

Review of the resident's progress notes revealed at time of incident, staff #127 was providing care to another resident in a nearby room and heard a loud bang coming from resident #002's room. The resident's room door was closed and staff #127 opened the door and found the resident had fallen outside the specified area.

Interview with staff #127 stated that he/she assisted the resident back to bed. Staff #127 verbalized he/she was aware that according to the home's policy, resident must not be moved after an unwitnessed fall until assessed by a Registered Nurse.

Interview with staff #128 indicated when he/she arrived to the resident's room, the resident was already in his/her bed. Staff #128, #109 and #124 indicated resident found after an unwitnessed fall was not to be moved until a full assessment was conducted by the registered staff.

Interview with the DORC confirmed that the home's policy of fall management was not complied with by staff #127. [s. 8. (1) (a),s. 8. (1) (b)] (512)
(512)

2. The licensee has failed to ensure that the home's fall management policy is complied with.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device during the provision of care and was found two hours later unresponsive.

Review of the home's policy titled Fall Prevention and Management Program, policy number R.C. - 4.7 with revision date of July 2016, under section B, Post Fall Assessment and Management, item #2 stated: do not move the resident, even though there is no apparent injury notice, until a full head to toe

assessment has been conducted.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of staff #131. They used a transfer device to restraint the resident and he/she was left unattended. Staff #111 stated 45 minutes after, he/she had told assigned staff #118 that the resident was still in the specified location. Staff #111 then went on to assist with other residents on his/her own assignment.

Interview with staff #118 indicated he/she was very busy on the identified shift when the incident occurred, so that he/she had forgotten what staff #111 had told him/her about resident #001. Staff #118 admitted he/she neglected to check on the resident which he/she should have done. After the resident was discovered he/she assisted to release the resident from the restraint. Staff #118 stated he/she was frightened and did not know what to do. He/she could not recall who had given the instruction to transfer the resident back to the room. Staff #118 verbalized understanding of the home's policy not to move the resident after an unwitnessed fall until a full head to toe assessment has been conducted.

Interview with staff #110 stated after becoming aware of the incident he/she rushed to the nursing station, called staff #129 and #118. All staff assisted in releasing the resident from the restraint, could not recall who gave the suggestion to move the resident onto the wheelchair and transported back to his/her own bed. Interview with staff #101 stated the resident was already in bed unresponsive when he/she arrived.

Interviews with staff #111, #118, and #129, indicated after an unwitnessed fall, resident #001 was moved from the floor to a wheelchair and then was transferred back to his/her own bed before a full head to toe assessment by the registered nursing staff was completed. Interviews with staff #109, #112, and the DORC confirmed that the home's policy on fall prevention and management of not moving the resident after an unwitnessed fall was not complied with. [s. 8. (1) (a),s. 8. (1) (b)] (512)

(512)

3. 3. The licensee has failed to ensure that the home`s policy on continence care and bowel management put in place is complied with.

The home's policy titled Continence Care and Bowel Management Program policy number RC-4.6.2 with revision date of July 2016 was reviewed. Under the Procedure section, item #4 stated that any resident requiring support in a sitting position must not be left unattended. Under same section, item #10 stated that under no circumstances shall resident be restrained while using specified equipment.

A CIS was submitted to the MOHLTC related to fall. The CIS further revealed that on an identified date resident #001 was found having fallen on the floor while care was being provided with a transfer device.

Review of the home's investigation notes indicated resident #001 was restrained in a transfer device for during the provision of care and was found two hours later unresponsive.

Interviews with staff #111 indicated on an identified date he/she provided care to resident #001 with assistance of PSW #131. They used a transfer device to restraint the resident to prevent him/her of exhibiting an identified responsive behaviour. PSW #111 stated that using the transfer device to restraint the resident during care was a common practice on the unit for long period of time from 20 minutes to sometimes over an hour.

Interview with staff #118 indicated similar rationale for using the transfer device during resident #001's specified care. Staff #118 stated he/she was very busy on the day shift of an identified date, that he/she had forgotten what staff #111 had told him/her about resident #001 still in a specified location. Staff #118 admitted he/she was neglectful to check on the resident which she should have done.

Review of the resident written plan of care with an identified date, revealed the resident was cognitively impaired, had a specified medical condition, and exhibited specified responsive behaviour. The resident was described as frequently incontinent of bladder function, required scheduled toileting and the use of incontinent products. There was no indication that the resident was to use a transfer device during the specified care.

Interviews with staff #111, #118, #101, #129, and #130, indicated a transfer device had been used for months for resident #001 before the incident.

Interviews with the DORC who was the lead of the continence program confirmed that staff #111 and #118 did not comply with the home's policy on not leaving resident who required support in a sitting position unattended and restraining resident while providing the specified care.

The severity of these incidents is actual harm as the residents had sustained injury. The scope of these incidents is isolated to the above mentioned two residents. There is on-going non-compliance to a voluntary plan of correction (VPC) issued in similar area to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 8. (1) (b)] (512)

(512)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 04, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 31st day of July, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Tilda Hui

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