Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2017_569508_0002	035508-16	Resident Quality Inspection

Licensee/Titulaire de permis

ALBRIGHT GARDENS HOMES INC.
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

ROSEANNE WESTERN (508), KELLY CHUCKRY (611), KERRY ABBOTT (631)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 4, 5, 6, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, 2017.

During this inspection the Inspectors toured the facility, observed provision of care, reviewed resident clinical records, staffing schedules, relevant policies and procedures, interviewed residents, staff and family members. The following inspections were conducted concurrently during this Resident Quality Inspection: Complaint inspections, log #011750-15, related to resident care, log #014599-15, related to not involving the Substitute Decision Maker (SDM), log #025748-15, related to infection control practices, log #030279-16, log #034128-16, related to no 24/7 Registered Nurse (RN), log #030551-16 related to refusal of admission, log #031522-16, log #031948-16, log #034746-16, log #01803-17, related to care not being provided due to staffing shortages and Critical Incident (CI), log #021266-15, related to falls with injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Nursing Officer (CNO), the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinators, the Food Service and Nutrition Manager, the Environmental Service Manager, the Registered Dietitian (RD), the Wound Care Nurse, the Nursing Unit Clerk, registered staff and Personal Support Workers (PSW),

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **10 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident was assessed and that where the circumstances of the resident was required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #024 had three falls that resulted in an injury to the resident over a four month period in 2015.

On an identified date in 2015, the resident fell while attempting to self-transfer. The resident sustained an injury and was transferred to hospital where the resident had surgery and was admitted. The resident was re-admitted back to the home.

The resident had a second fall when the resident attempted to self-transferred and was found on the floor. The resident sustained an injury, was transferred to hospital for surgery and admitted to the hospital.

Approximately two months later, the resident was found sitting on the floor due to attempting to self-transfer. The resident sustained an injury and was transferred to hospital for treatment. The resident returned to the home with a clincial intervention in place.

A review of the resident's clinical record indicated that post fall assessments had not been conducted using a clinically appropriate assessment instrument that was specifically designed for falls after any of these falls. It was also revealed that staff were not completing post fall assessments after residents had a fall, only a fall risk assessments. This information was confirmed during an interview with the CNO on January 26, 2017, and through review of the resident's clinical record.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) inspection, log #021266-15, conducted concurrently during this Resident Quality Inspection. [s. 49. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

During the initial tour of the home on January 4, 2017, it was observed that a utility room door that was accessible to residents was unsafely propped open using a ladder. A maintenance cart was easily accessible as well. This cart had various tools including a drill with a large drill bit secured in the drill.

This door was unsafely propped open for an excess of thirty minutes, at which time staff #118 confirmed this door should be locked at all times and cart should be inaccessible to residents. Staff #117 further confirmed that the door should have been closed and locked to ensure resident safety.

An interview with the Administrator confirmed that the door being unsafely propped open posed a safety concern for residents. [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

The home failed to ensure that a registered nurse (RN) was on duty and present in the home on the following dates and times;

June 9, 2016 from 1830 hours to 2230 hours
September 14, 2016 from 0330 hours to 0630 hours
October 18, 2016 from 2230 hours to 0630 hours
November 9, 2016 from 2230 hours to 0630 hours
December 4, 2016 from 2230 hours to 0630 hours
December 15, 2016 from 2230 hours to 0630 hours

Discussions with the Administrator and the CNO revealed that due to RN shortages, the home had started to use agency staff and were currently trying to recruit staff as well to try to cover RN shifts; however, it was confirmed through review of the staffing schedules and during interviews with staff #107, the Administrator and the CNO that these identified shifts were not filled with a RN. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was complied with in accordance with Regulation 48 (1), every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home.

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

4. A pain management program to identify pain in residents and manage pain.

A) A review of resident #006's clinical record indicated that on an identified date in 2016, the resident had acquired an alteration in skin integrity. A further review of the resident's

clinical record indicated that the alteration in skin integrity was re-assessed on a later date and was found to have deteriorated. A review of the home's policy for Skin and Wound Care, N-9.14.6, under Pressure Ulcers, provided staff specific instructions. A review of the resident's plan of care indicated that specific monitoring actions were not completed during that twenty-four week period.

An interview with registered staff #111 confirmed that the specific monitoring actions were not completed.

B) A review of the home's policy for Skin and Wound Care, N-9.14.6, under Pressure Ulcers, "The Skin Care Coordinator will collect wound information of the Skin Integrity Tracking sheets on the first week of every month for quality monitoring purposes. Copies of the Skin Integrity Tracking sheets will be given to the Director of Nursing".

An interview with the Skin Care Coordinator registered staff #111 as well as the Resident Assessment Instrument (RAI) Coordinator confirmed that Skin Integrity Tracking Sheets were not completed in the home. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of resident #006's electronic Medication Administration Record (eMAR) over a five month period, revealed that the resident was administered an analgesic four times daily.

A review of the home's Pain Management Policy stated, "Each Resident will receive a formal pain assessment on admission, re-admission, quarterly and with any significant change in health condition. RAI-MDS 2.0 assessment protocols and outputs will be reviewed in related to pain and pain control with each new full assessment.

Currently the tool in use is the Pain Assessment Record on Point Click Care". A review of the resident's Pain Assessment Record on Point Click Care indicated that staff were not completing pain assessments quarterly. The most recent pain assessment that was completed was on an identified date in 2014. An interview with registered staff #111 confirmed this information. [s. 8. (1) (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 to ensure that 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, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #012 was identified as requiring the use of bedrails in the raised position on their bed. Upon observation for this resident, a specific type of bedrails were observed in the up position. The home does not have a process in place to ensure that this resident was assessed for the use of these bedrails.

An interview conducted with the CNO and DOC confirmed that this assessment was not completed for the bed system for resident #012 to minimize the risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. the program must be evaluated and updated at least annually in accordance with the evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's annual program evaluations for 2016 indicated that the home had not completed their annual evaluation for the following programs: Skin and Wound Care, Falls Prevention and Management, Continence care and bowel management and Pain Management.

An interview with the Chief Nursing Officer (CNO), confirmed that the annual evaluations for 2016 was not completed for these programs. [s. 30. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary program require under section 48 of this Regulation: 3. the program must be evaluated and updated at least annually in accordance with the evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of resident #201's written plan of care indicated that this resident was to receive a shower on two specific dates each week. Point of Care (POC) was reviewed as it related to bathing for resident #201. During a four week review of a specific month in 2016, this resident was to have received eight showers. According to the follow up question report for this resident, they received a total of four showers during this period of time. One response was documented as not applicable. The following month, the resident was to have received seven showers. According to the follow up question report for this resident, they received a total of five showers.

A review of resident #200's written plan of care indicated that this resident was to receive

a shower or a bath on two specific dates each week. POC was reviewed as it related to bathing/showering for resident #200. During a four week review of a specific month in 2016, this resident was to have received eight baths/showers. According to the follow up question report for this resident, they received a total of one shower. The following month, the resident was to have received eight baths/showers. According to the follow up question report for this resident, they received one bath. Some of the responses were documented as resident refusals.

A review of resident #202's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #202. During a four week review of a specific month in 2016, this resident was to have received nine baths. According to the follow up question report for this resident, they received a total of four baths and one shower. Some of the responses were documented as not applicable. The following month, this resident was to have received a total of seven baths. According to the follow up question report for this resident, they received three baths. One response was documented as not applicable and one response was documented as a resident refusal.

A review of the written plan of care for resident #203 indicated that this resident was to receive a shower on two specific dates each week. POC was reviewed as it related to showers for resident #203. During a four week review of a specific month in 2016, this resident was to have received eight showers. According to the follow up question report for this resident, they received four showers. Some of the responses were documented as not applicable. The following month, this resident was to have received a total of seven showers. According to the follow up question report for this resident, they received a total of five showers. Some responses were documented as not applicable.

A review of the written plan of care for resident #204 indicated that this resident was to receive a bath on on two specific dates each week. POC was reviewed as it related to baths for resident #204. During a four week review of a specific month in 2016, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four showers and one bath. Some responses were documented as not applicable.

A review of the written plan of care for resident #008 indicated that this resident was to receive a bath on on two specific dates each week. POC was reviewed as it related to baths foe resident #008. During a four week review of a specific month in 2016, this resident was to have received a total of eight baths. According to the follow up question

report for this resident, they received a total of four baths. One response was documented as not applicable. During the month of January, 2017, this resident was to have received a total of seven baths. According to the follow up question report for this resident, they received a total of five baths. One was documented as the resident was not available.

A review of the written plan of care for resident #007 indicated that this resident was to receive a shower on two specific dates each week. POC was reviewed as it related to showers for resident #007. During a four week review of a specific month in 2016, this resident was to have received a total of nine showers. According to the follow up question report for this resident, they received a total of six showers. One was documented as a resident refusal. The following month, this resident was to have received a total of seven showers. According to the follow up question report for this resident, they received a total of five showers. One was documented as not applicable.

A review of the written plan of care for resident #207 indicated this resident was to have received a shower on two specific dates each week. POC was reviewed as it related to showers for resident #207. During a four week review of a specific month in 2016, this resident was to have received a total of nine showers. According to the follow up question report for this resident, they received a total of six showers. The following month, this resident was to receive a total of seven showers. According to the follow up question report for this resident, they received a total of five showers. One was documented as not applicable.

A review of the written plan of care for resident #208 indicated that this resident was to have received a shower or bath on two specific dates each week. POC was reviewed as it related to showers/baths for resident #208. During a four week review of a specific month in 2017, this resident was to receive a total six showers/baths. According to the follow up question report for this resident, one shower/bath was documented as not applicable.

A review of the written plan of care for resident #209 indicated that this resident was to have received a shower on two specific dates each week. POC was reviewed as it related to showers for resident #209. During a four week review of a specific month in 2016, this resident was to have received a total of nine showers. According to the follow up question report for this resident, they received a total of four showers, two baths, and two bed baths. One was documented as not applicable.

A review of the written plan of care for resident #210 indicated that this resident was to have received a bath on two specific dates each week. POC was reviewed as it related to baths for resident #210. During a four week review of a specific month in 2016, this resident was to have received a total of nine baths. According to the follow up question report for this resident, they received a total of five baths. Two were documented as not applicable.

A review of the written plan of care for resident #211 indicated that this resident was to have received a shower on two specific dates each week. POC was reviewed as it related to showers for resident #211. During a four week review of a specific month in 2016,this resident was to have received a total of eight showers. According to the follow up question report for this resident, they received a total of six showers. The following month, this resident was to have received a total of seven showers. According to the follow up question report for this resident, they received a total of four showers, and one bath. One was documented as not applicable.

Interviews conducted with staff #114, #115, and #116 confirmed that on occasions when short staffed baths are not being completed in the home. In addition, it was confirmed that staff members are documenting not applicable when bathing is not being completed. An interview conducted with the CNO confirmed that the home is aware that they are short staffed at times in the home and further confirmed that they have been made aware that staff are documenting not applicable when baths are not completed. It is the home's expectation that baths are completed for every resident twice a week, unless indicated differently in the plan of care. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an unidentified date in December, 2016, resident #021 developed an alteration in skin integrity. Later that month, the Physician ordered a treatment for the wound. A review of the resident's clinical record indicated that no skin assessments were conducted using a clinically appropriate assessment instrument specifically designed for skin and wound assessments.

Although treatments were being done on the resident's alteration in skin integrity, a skin assessment had not been conducted by a member of the registered nursing staff until approximately one month later.

It was confirmed during an interview with staff #111 on January 25, 2017, that the resident who exhibited altered skin integrity did not receive a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) A review of resident #006's clinical record indicated that on an identified date in 2016, the resident had acquired an alteration in skin integrity. A further review of the resident's clinical record indicated that the alteration in skin integrity was re-assessed on a later date and was found to have deteriorated. A review of the resident's plan of care indicated that only three weekly assessments were completed over the twenty-four week period.

An interview with registered staff #111 confirmed that registered nursing staff were expected to assess pressure ulcers at least weekly and weekly assessments were not completed for resident #006's pressure ulcer. [s. 50. (2) (b) (iv)]

3. B) Resident #021 developed an alteration in skin integrity on an unidentified date in December, 2016. Later that month, the Physician ordered a treatment.

A review of the resident's clinical record indicated that the alteration in skin integrity had not been assessed at least weekly.

It was confirmed during an interview with staff #111 on January 25, 2017, that the resident who exhibited altered skin integrity was not being reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibited altered skin integrity receive a skin assessment by a member of the registered nursing staff receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and that these residents are reassessed at least weekly by a registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to resident received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations.

According to section 221(1) of the Regulations; for the purposes of paragraph 6 of subsection 76(7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls Prevention and management
2. Skin and wound care
3. Continence care and bowel management
4. Pain management, including pain recognition of specific and non-specific signs of pain.

An interview with the Chief Nursing Officer (CNO) confirmed that the above noted training requirements had not been completed for any staff in 2016. [s. 76. (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 that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations. According to section 221(1) of the Regulations; for the purposes of paragraph 6 of subsection 76(7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls Prevention and management
2. Skin and wound care
3. Continence care and bowel management
4. Pain management, including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that, if the home was using a computerized system to monitor the water temperature, the system was checked daily to ensure that it was in good working order.

The home used a computerized system to monitor the water temperatures in the home. A review of the domestic hot water temperature records from September, 2016 to January, 2017 was conducted. These water temps were recorded during regular business hours when maintenance staff were scheduled to work in the building. These readings were not checked daily.

An interview conducted with the environmental services manager confirmed that computerized water temperatures were not checked daily. The DOC confirmed that nursing staff do not check water temps in the absence of maintenance staff. [s. 90. (2) (j)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's 2016 annual program evaluations indicated that the Infection Prevention and Control program was not completed.

An interview with the Chief Nursing Officer confirmed that the 2016 annual program evaluation for the Infection Prevention and Control program was not completed. [s. 229. (2) (d)]

2. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the initial tour of the home, the observation of tub rooms took place. A significant amount of personal hygiene items were noted to be unlabelled.

The fifth floor was observed to have a razor, two toothbrushes, mouthwash, toothpaste and two nail clippers all used and unlabelled.

The fourth floor north east tub rooms were noted to have two razors, two hairbrushes, a comb, shaving cream and face scrub, all used and unlabelled.

The fourth floor south west tub rooms were noted to have two hairbrushes, two deodorants, lotion, nail clippers, conditioner, body wash, petroleum gel, and two powders, all used and unlabelled.

The third floor tub rooms were noted to have roll on deodorant, body lotion, a comb, fragrance mist, wooden nail sticks, and shaving cream all used and unlabelled.

The second floor tub rooms were noted to have nail clippers, chapstick, petroleum gel, three brushes, deodorant and antiperspirant spray, all used and unlabelled.

An interview with the DOC confirmed that it was the home's expectation that all resident's personal items were labelled and that the staff did not participate in the implementation of the infection prevention and control program in the home. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

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

The written plan of care for resident #012, under the focus of mobility, indicated that this resident used bed rails for mobility in bed. Further review of the kardex, identified that a specific type of bed rails were to be in the up position for safety.

Resident was observed to be in bed, with another type of bed rails in the raised position. An interview conducted with identified staff #103 confirmed that the information on the kardex was incorrect. A subsequent interview conducted with the DOC confirmed that the written plan of care did not provide clear direction to staff as it related to side rail use. [s. 6. (1) (c)]

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

Resident #015 was admitted to the home on an identified date in 2016. A review of the 24 hour Initial Admission Assessment completed the same day, indicated that the resident was totally incontinent for both bowel and bladder. The Minimum Data Set (MDS) coding indicated that the resident was continent for bowel and usually continent for bladder.

The resident's seven day assessment form which was initiated on the date of admission, indicated that during this observation period the resident had episodes of bladder incontinence; however, a continence assessment completed nine days after admission, indicated that the resident was continent for both bowel and bladder.

It was confirmed during an interview with the RAI Coordinator on January 26, 2017, that the staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of

care.

On an identified date in 2015, resident #029 sustained an injury. It could not be determined how the resident sustained this injury as the resident was confused and unable to inform anyone of how it happened. During a visit from a family member, the family member had noticed the resident's injury and called the resident's SDM to inform her that the resident sustained an injury.

Documentation in the resident's clinical record indicated that the resident's SDM had to inquire about the resident's injury. The Director of Nursing discussed the incident with the resident's SDM after assessing the resident and confirmed that the staff should have informed the resident's SDM of the injury of unknown origin.

It was confirmed through review of the clinical documentation that the SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #014599-15, conducted concurrently during this Resident Quality Inspection. [s. 6. (5)]

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

A) A review of resident #200's written plan of care indicated that this resident was to receive a shower or a bath on two specific dates each week. Point of Care (POC) documentation for this resident as it related to bathing indicated that resident #200 was to receive a bath before a certain time or the bath would be refused.

POC was reviewed as it related to bathing/showering for resident #200. Over a two month period, this resident refused a bath/shower a total of eight times. All of these refusals were documented as being offered after this specific time, which was outside the period of time identified in the plan of care for resident #200.

An interview conducted with the CNO confirmed that the care set out in the plan of care for resident #200 was not provided as specified in the plan. [s. 6. (7)]

5. B) Resident #015 was assessed by the Registered Dietitian (RD) as a high nutritional

risk. The RD ordered an intervention to be given to the resident as directed.

A review of the Point of Care (POC) documentation for resident #015, indicated that the intervention had not been provided to the resident as directed in the resident's plan. This intervention was only provided three times over a four week period when it should have been provided almost daily.

It was confirmed by the Registered Dietitian (RD) during an interview that this intervention should have been offered to the resident as directed and that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they kept a written record related to each evaluation under clause (3) (e) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes that were implemented.

The home had a policy entitled, Staff Placement and Replacement (N-5.6) from the nursing policy and procedure manual. This document is what the home refers to as their staffing plan. This document was last reviewed and revised on February 2008.

An interview conducted with the CNO confirmed that the home does not complete a written record related to the evaluation of this staffing plan. In addition there is no evidence of any changes and dates of implementation. [s. 31. (4)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the applicant's admission to the home was approved unless,

(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

On an identified date in 2016, the home provided an applicant with a written letter indicating that the resident’s acceptance for admission had been declined because the home was not able to manage the resident’s care needs.

An interview with the Chief Nursing Officer (CNO) confirmed that the home had provided care for other residents that had similar care needs and that the staff in the home were educated in managing these care needs.

The reason for this refusal did not meet the grounds for withholding approval as specified in the legislation. [s. 44. (7)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

During a complaint inspection conducted concurrently with this RQI, the complainant had revealed to Inspector #631 that she had brought forth concerns to the CNO in 2015 related to a number of resident care issues. During this inspection, the current CNO could not produce any documented concerns from 2015 related to this complaint and also confirmed that there was no documented record of concerns from 2016.

An interview with the Chief Nursing Officer confirmed that a documented record that included items as outlined above was not maintained in the home. [s. 101. (2)]

Issued on this 23rd day of February, 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) :	ROSEANNE WESTERN (508), KELLY CHUCKRY (611), KERRY ABBOTT (631)
Inspection No. / No de l'inspection :	2017_569508_0002
Log No. / Registre no:	035508-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
Licensee / Titulaire de permis :	ALBRIGHT GARDENS HOMES INC. 5050 Hillside Drive, Beamsville, ON, L0R-1B2
LTC Home / Foyer de SLD :	Albright Gardens Homes, Incorporated 5050 Hillside Drive, Beamsville, ON, L0R-1B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William ter Harmsel

To ALBRIGHT GARDENS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (2) in keeping with r. 299 of the Regulations. This is in respect to the severity of minimal harm or potential for actual harm, the scope of a pattern and the home's history of non compliance previously issued in an unrelated area.
.

The licensee shall:

1. Implement a clinically appropriate assessment instrument specifically designed for falls;
2. Educate all registered nursing staff, including any agency registered nursing staff on the home's Falls Prevention and Management program, including the requirements and use of the post-fall assessment instrument.
3. Review the clinical records of residents who have been identified as a high risk for falls to ensure that their plans have been reviewed, revised and ensure that the interventions are implemented.

Grounds / Motifs :

1. The licensee failed to ensure that when the resident has fallen, the resident was assessed and that where the circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #024 had three falls that resulted in an injury to the resident over a four month period in 2015.

On an identified date in 2015, the resident fell while attempting to self-transfer. The resident sustained an injury and was transferred to hospital where the resident had surgery and was admitted. The resident was re-admitted back to the home.

The resident had a second fall when the resident attempted to self-transferred and was found on the floor. The resident sustained an injury, was transferred to hospital for surgery and admitted to the hospital.

Approximately two months later, the resident was found sitting on the floor due to attempting to self-transfer. The resident sustained an injury and was transferred to hospital for treatment. The resident returned to the home with a clincial intervention in place.

A review of the resident's clinical record indicated that post fall assessments had not been conducted using a clinically appropriate assessment instrument that was specifically designed for falls after any of these falls. It was also revealed that staff were not completing post fall assessments after residents had a fall, only a fall risk assessments. This information was confirmed during an interview with the CNO on January 26, 2017, and through review of the resident's clinical record.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) inspection, log #021266-15, conducted concurrently during this Resident Quality Inspection. [s. 49. (2)] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 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 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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