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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 4, 2016	2016_285126_0003	003325-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET OTTAWA ON K1S 5G6

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

GLEBE CENTRE
950 BANK STREET OTTAWA ON K1S 5G6

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

LINDA HARKINS (126), ANANDRAJ NATARAJAN (573), JOANNE HENRIE (550), LISA KLUKE (547), PAULA MACDONALD (138)

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): February 8, 9, 10, 11, 12, 17, 18, 19, 22, 23, 24 ,25 , 26,2016

During this RQI, three Critical Incident Reports and one complaint were inspected.

During the course of the inspection, the inspector(s) spoke with The Executive Director, the Director of Care, the Manager of Nursing Care Operations, the Director of Quality Management, the food Service Manager, the Director of Environmental Services, the Director of Residents Services, the Volunteer Coordinator, several Registered Nursing staff, several Personal support workers, several Dietary Aids, one cook, several Activity staff, the President of the Resident Council, the President of the Family Council, several residents and several family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

11 WN(s)
3 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 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 resident # 051 was protected from physical abuse by Resident # 050.

In accordance with O. Regs 2. (1) (c) physical abuse is define as "the use of physical force by a resident that causes physical injury to another resident".

The home submitted a Critical Incident Report on a specific day of November, 2015 for a resident to resident abuse. On a specific day of November,2015, resident #050 had an altercation with resident #051 in the dining room in the afternoon. Resident #050 punched and hit resident #051 on the top of the head which resulted in a "skin /scratch opening".

On February 26, 2016, Inspector #126 interviewed Registered Nurse (RN) #132 via telephone. RN #132 indicated that she was doing the documentation in the alcove when he/she heard people screamed and found resident #051 right beside resident #050 and observed resident #050 hitting resident #051 on the head. RN #132 did not know how or who brought resident #051 into the dining room or how he/she got beside resident #050.At that time, resident #051 was identified as receiving palliative care and could not propel independently from the bedroom to the dining room. Resident #051 passed away 4 days after the incident not related to the injury.

On February 26, 2016, Inspector #126 interviewed four staff and one student who worked on that specific day of November 2015, on the day shift. None of them remembered who was assigned resident #051 or who brought the resident to the dining room on that day. Also staff did not remember if resident #051 was in the dining room for the whole period of 12:00-14:25 hrs.

Resident #050 was admitted to the home in 2011 with several diagnosis. Resident #050's health care record was reviewed for the period of October 2014 to the date of this inspection. There were several incidents of physical aggressive behaviors involving several residents. The following incidents were documented under behaviors notes:

1) On a specific day of October 2014 resident #050 was involved in a resident to resident abuse. A resident opened the door of resident #050, who responded by punching the resident in the face and knocking him/her on the floor. No injury documented.
2) On a specific day of October 2014 a resident was meddling with his/her spoon and resident #050 attempted to punch the co-resident. No injury documented.
3) On a specific day of December, 2014, while resident #050 was sitting in the dining room counting his/her money/coins, punched another co-resident on the face as the resident was standing beside and talking to him/her. No injury documented.
4) On a specific day of January 2015, resident #050 was yelling at a co-resident who was wandering the unit and outside the door. The co-resident reported that resident #050 hit him/her on the face. No bruising observed.
5) On a specific day of February 2015, resident #050 slapped a co-resident as he/she tried to take a chair from the table at lunch time.
6) On a specific day of March 2015, resident #050 hit a co-resident to the right hand with a cup when both were sitting at resident #050's table. Resident #050 initiated physical and verbal aggression. No injury to co-resident.
7) On a specific day of October 2015, resident #050 hit a co-resident on the top of the head with his/her closed fist in the evening. Co-resident was sitting in a chair that resident #050 usually sits in. Resident #050 was observed to be trying to tip over the chair to remove co-resident from chair. No injury to co-resident.

Nursing staff, on the unit indicated that resident #050 is very territorial and they have to ensure that other co-resident does not get close to him/her. The plan of care dated October 2015, identifies resident #050 to be removed from public area when behavior is disruptive/ unacceptable and that he/she is very protective of the space/territorial, to ensure to redirect co-res to proper chair. It is also documented to refer to the BSO if needed for behavioral management. No documentation was found related to BSO referral or to the Psychogeriatric Team for behavior management.

On a specific day of November 2015, Resident #050 was left in the dining room, unsupervised with resident #051 who got close to him/her and was hit on the head which caused an injury. Resident # 050 was known to be territorial and reacts by physical aggression to co-residents. During the course of this inspection, resident #050 was

observed on several occasions by Inspector #126 to be sitting at his/her table without any supervision and other resident wandering in the dining room. Several staff on different unit were interviewed and indicated that residents that have cognitive impairment and are exhibiting inappropriate behaviours (sexual, physical assault) have no intent of injuring the other residents.

The licensee has failed to protect resident #051 from physical abuse by resident #050 by not implementing the interventions as identified in the plan of care. (Log # 031423-15) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident equipment are kept clean and sanitary.

The following resident equipment was noted to be unclean:
Inspector #573 observed food debris on the footrests for resident #040's wheelchair and food stains on the left side seat cushion on February 8, 2016.

Inspector #126 observed food debris and dust on resident #016's wheelchair on February 9, 2016.

Inspector #573 observed resident #031's wheelchair unclean with the right arm rest had dried white matter and the left arm rest had food stains. Resident #031 indicated on February 9, 2016 to Inspector #573, that the staff don't clean the wheelchairs.

Inspector #550 observed resident #014's wheelchair to be dirty with lots of dust all over, the back rest was full of the resident's hair, the lower left side of the wheelchair is visibly dirty with splatters of a white substance and the foot rest is dirty with food splatters on February 10, 2016.

Inspector #126 observed food debris and dust on resident #023's wheelchair on February 10, 2016.

Inspector #547 reviewed the home's process for cleaning of resident's equipment cleaning schedule for the Lindenwood unit on February 19, 2016 provided by the Director of Care (DOC). The DOC identified that the home expects the night shift Personal Support Workers (PSW's) follow a rotation schedule for the cleaning of residents equipment on every unit. The DOC was not able to locate any policy and procedure for this, however provided the units cleaning schedule and the night shift scheduled tasks that are to be completed nightly. Upon review of the nightly cleaning schedule, it was noted that resident #014 and #016 were not identified on this schedule to have their chairs cleaned on any night of the week.

Inspector #547 returned to the Lindenwood unit to observed these wheelchairs, and observed resident #014's wheelchair to have some dried food matter on the back of her seat cushion, however PSW #102 indicated that she had washed down the resident's chair that day quickly to bring her to the living area as she noted that the resident's chair was soiled. PSW #102 indicated that this was not her usual task, however did this extra task today for the resident. Inspector #547 then observed resident #046 seated next to resident #014 in the living room and had a significant build up of dust and debris, with several dried food stains on the resident's seat cushion. Resident #046 was also noted to not be scheduled to have her wheelchair cleaned on the nightly cleaning schedule.

Inspector #547 then observed resident #016's wheelchair to be heavily soiled with food and dust matter, the seat cushion had dried food stains. Resident #016 indicated to Inspector #547 that he was embarrassed about the state of his chair when he goes out, as he knows it is dirty, but that his chair is the only way for him to go outside and he has no choice.

On February 19, 2016 the DOC indicated to Inspector #547 that the home will have to review the process for cleaning of residents ambulation equipment and how they are updated as residents equipment needs change. Resident #014 was recently assessed to need to use a wheelchair and resident #016 and #046 were new to the home since that schedule was developed March 2015. The DOC indicated that the wheelchairs were soiled as they had not been added to the cleaning schedule on the unit. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home furnishings and equipment are maintained in a safe condition and in a good state of repair.

On February 10, 2016, Inspector #126 observed a cracked commode chair seat in a bathroom shared by two residents.

On February 18, 2016, interview held with PSW #105 who indicated that if they found a broken equipment, they would take it away, to get it repaired or replace it if they can by putting in a working order. PSW #105 indicated that she was not aware that the commode chair was cracked. Discussion held with the Clinical Manager who indicated that if equipment was broken it shall be taken away and a work order shall be completed.

On February 18, 2016 Inspector #126 observed the cracked commode chair seat in a bathroom shared by two residents was not repaired or taken away since initially observed on February 10, 2016. [s. 15. (2) (c)]

3. The licensee has failed to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair.

The following non-compliance is related to equipment associated with the resident-staff communication and response system (the call bell system). It was observed by the inspectors that the call bell system is available at each resident's bedroom and bathroom. When the call bell system is engaged a dome light at the entrance of the resident's room will illuminate, a sound from an annunciator panel at the nurses station will alarm along with a visual display of the location where the call bell was engaged, and a page outlining the location of the call bell that was engaged is sent to a pager carried by the PSW staff members on specific units in the home.

On February 08, 2016 on sixth floor unit, room W617A and W617B, Inspector #573 observed that the call bell system in bed room and the bathroom was not working. Inspector spoke with PSW #118 and PSW #119 who worked on the unit, both confirmed

that the call bell system was not working. When Inspector enquired regarding the PSW #119's pager who indicated that her pager is also not in working condition. PSW #118 indicated to the inspector that he did not have a pager.

On February 09, 2016 on second floor unit, room L206A, Inspector #545 observed that the cord and the mechanism that activities the call bell system in the bathroom was in disrepair.

On February 09, 2016 on second floor unit, Inspector #126 spoke with PSW #114 and PSW #101 both indicated that their pager were not in working condition.

On February 09, 2016 on fourth floor unit, Inspector #573 engaged the call bell in room Q405A. PSW #120 arrived at the room and indicated that she saw the light illuminate outside the resident's room. When inspector enquired regarding PSW #120 pager she indicated that she did not have a pager. Further the PSW staff indicated that there are four PSW staffs in the floor but only two working pagers are available for PSW staffs in the floor.

On February 09, 2016 on fifth floor unit, Inspector #573 spoke with PSW #121 who indicated that during morning shift there are four PSW staffs in the floor and none of the PSW staffs have pagers in working condition.

On February 10, 2016 on sixth floor unit, Room W606A, Inspector #573 observed that call bell system in bed room was not working. Inspector spoke with PSW #122 in the floor who confirmed that the call bell system was not working. When Inspector inquired regarding the PSW #122 pager, she indicated that her pager is also not working.

On February 11, 2016 discussions held with the home's Director of Environmental Services, who confirmed to Inspector #573 that on February 10, 2016 his maintenance staff identified six rooms in sixth floor with call bell disrepair and further indicated that all the PSW staffs on the unit should have a working condition pager. The Director of Environmental Services further stated to inspector that there were ongoing maintenance issues with the resident-staff communication and response system and the availability of working pagers to PSW staffs in the building.

It has been noted that non-compliance under this section was found during: RQI in February, 2015 Inspection 2015_284545_0003. [s. 15. (2) (c)]

4. The licensee has failed to ensure that the home, equipment are maintained a good state of repair such as functional pagers, are readily available at the home to meet the nursing and personal care needs of residents.

For the purposes of this report, pagers are used by PSW staff members to enable the resident staff communication and response system by directly notifying PSW's when a call for assistance is engaged.

On February 08, 2016 on sixth floor unit, while inspecting resident-staff communication and response system (the call bell system) function, Inspector #573 inquired PSW #119's regarding the functionality of pager. PSW #119 indicated that her pager was not in working condition. PSW #118 working on the same unit indicated to the inspector that he did not have a pager.

On February 09, 2016 on second floor unit, Inspector #126 spoke with PSW #114 and PSW #101. Both indicated that their pager were not in working condition.

On February 09, 2016 on fourth floor unit , Inspector #573 engaged the call bell system in room Q405A. PSW #120 arrived at the room and indicated that she saw the light illuminate outside the resident's room. When Inspector inquired regarding PSW #120 pager, she indicated that she did not have a pager. The PSW staff indicated that there are four PSW staffs working on the unit but only two pagers are available for PSW staffs use.

On February 09, 2016 on fifth floor unit, Inspector #573 spoke with PSW #121 who indicated that during morning shift there are four PSW staffs working on unit and none of the PSW staffs have pagers.

On February 11, 2016 on fifth floor unit, Inspector #573 spoke with the RPN in the presence the Director of Environmental Services who confirmed that the PSW staff don't have any pagers available on the unit.

On February 11, 2016 discussions held with the home's Director of Environmental Services, who indicated to Inspector #573 that all the PSW staff or each should have a working pager. The Director of Environmental Services further stated to inspector that there were ongoing issues with the availability of working pagers for PSW staff use in the building. [s. 15. (2) (c)]

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 resident equipment are kept clean and sanitary, equipment are maintained in a safe condition and in good state of repair (including residents equipment, associated with resident-staff communication and response system(call bell system),, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Regs 79/10 s.96. Every licensee of a long term care home shall ensure that the licensee's written policy under s. 20 of the Act to promote zero tolerance of abuse and neglect of residents.

The home does have a policy: Resident Abuse and Neglect # RC 08.03.02.

Under the procedures section it is required that:

"Employees or Board Members who are reporting that they have witnessed or suspect alleged incident of resident abuse or neglect: -Report any witnessed, suspected, or alleged abuse or neglect to the nurse on duty.

Nurse receiving report-Investigation;

-Ensure safety of staff and resident(s) involved and all other resident under his/her care
-conduct investigation using check list and incident report form...

Nurse receiving report-Reporting to Ministry of Health (MOHLTC)
-Notify the MOHLTC if the alleged, suspected or witnessed or un-witnessed incident of abuse or neglect of a resident meets the criteria for Ministry notification. The decision about whether to submit a report on an alleged incident of abuse or neglect will depend upon whether the circumstances of the alleged abuse or neglect meet the definitions of Abuse in LTCHA Section 2(1)Appendix A.
-Note : to submit a report to MOHLTC on weekends., Statutory Holidays or after business hours, the notification must be on the MOHLTC pager number. (See Appendix E: Table 1: Source MOHLTC Clarification of Mandatory and Critical Incident Reporting Requirements-August 4, 2010, p.2)
-Notify the Director of care or designate or if after hours, the manager on call immediately should the investigation lead to notification or reporting beyond the facility.

Personal Support Worker (PSW) #130 and Registered Practical Nurse (RPN) #131 failed to comply with the abuse policy of the home.

In accordance with O. Regs. 79/10, S.2 (1) (b) sexual abuse is define as "any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed toward a resident by a person other than a licensee or staff member."

The home submitted a Critical Incident Report on a specific day of November 2015 for a resident to resident abuse. PSW #130 observed resident #052 unbuttoning his/her shirt and going into resident # 053's room. By the time, PSW #130 arrived in resident #053's room, resident #052 was touching the breast of resident #053.

On February 24, 2016, Inspector #126 interviewed via telephone, PSW #130 regarding the incident of the specific day of November 2015. PSW #130 indicated that on that day, between 12:30-13:00hrs, he/she was sitting at the nursing station completing the documentation before her/his departure as he/she was finishing the shift at 13:00hrs. At that time, PSW #130 observed resident #052, unbuttoning his/her shirt and walking toward resident #053's room. PSW #130 immediately got up and walked toward resident #053's room. At that time, she observed resident #053 lying in the bed fully dress and resident #052 standing beside the bed, "rubbing resident #053 breast". PSW #130 redirected resident #052 out of the room with the assistance of PSW #132. PSW #130 left the unit as the shift was over and indicated that he/she did not notify the nurse

working on the unit because the nurse was gone for lunch. PSW #130 indicated that he/she informed RPN #131 the following morning on a specific day of November 2015.

Resident #052's health care record was reviewed. Resident #052 was admitted on a specific day of October 2015 with several diagnosis. It was noted in the progress notes that RPN #131 documented on the following day of the incident in November 2015: under "Behaviour Note: Today staff has told writer (resident # 052) was found partially clothed standing over the bed of a co-resident touching her/him inappropriately. Same staff who discovered him/her was also touched inappropriately". Inspector #126 was unable to interview RPN #131 because he/she is away on holidays.

On February 24, 2016, Inspector #126 interviewed the Director of Care (DOC) who indicated that the incident was reported to her by the Social Worker on a specific day of November 2015.The DOC initiated behavior mapping, notified the Substitute Decision Maker and notified the Director via Critical Incident System and started the investigation. PSW #130 reported the incident the next day and RPN #131 did not notify the Director. (Log # 030787-15) [s. 20. (1)]

2. Registered Nurse (RN) #132 failed to report immediately to the Director an incident of physical abuse as per the home Abuse and Neglect policy requirement.

In accordance with O. Regs 2. (1) (c) physical abuse is define as "the use of physical force by a resident that causes physical injury to another resident"

The home submitted a Critical Incident Report on a specific day of November 2015 for a resident to resident abuse. On a specific day of November 2015, resident #050 had an altercation with resident # 051 in the dining room in the afternoon. Resident #050 punched and hit resident #051 on the top of the head which resulted in a "skin /scratch opening". The Director was notified 2 days after the incident.

On February 26, 2016, Inspector #126 interviewed the Manager of Nursing Care Operations who indicated that she filled the Critical Incident on the Monday following the incident. She indicated that RN #132 called her about the incident and that it was the expectations that the Nurse who witnessed an incident of abuse shall immediately notify the MOHLTC. No documentation was found related to notifying the MOHLTC. (Log # 031423-15) [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The LTCH Licensee Confirmation Checklist - Infection Prevention and Control completed by the Manager of Nursing Care Operation and the Infection Control Nurse indicated that each resident is not screened for tuberculosis within 14 days of admission if a chest x-ray is required.

During an interview, the Manager of Nursing Care Operation and the Infection Control Nurse indicated to Inspector #550 that the home is following guidelines from the Ottawa Public Health Unit (PHU) for tuberculosis screening upon a resident's admission. These guidelines for the testing are that all residents being admitted who are less than 65 years old have a 2 step Mantoux done and all residents who are 65 years and older have a chest x-ray done. She indicated the chest x-ray requirement poses a significant

challenge to the home as most of the residents who are admitted are 65 years old or older and a chest x-ray is not always done before the residents are admitted. The challenge is to have them go to a clinic to receive a chest x-ray. She indicated the home is not compliant with this requirement of the legislation.

Inspector #550 reviewed the health care records of selected residents who were admitted to the home from November 25, 2015 to January 26, 2016 and observed documentation as follows:

Resident #043 was admitted to the home on a specific day of November 2015 and is less than 65 years old. As per PHU guidelines, this resident was required to have a 2 step Mantoux test for TB screening. It was documented the resident received the 1st step Mantoux in November 2015 and received the 2nd step in December 2015; 23 days post admission.

Resident #044 was admitted to the home on a specific day of December 2015 and is less than 65 years old. As per the PHU guidelines, this resident was required to have a 2 step Mantoux test for TB screening. It was documented the resident received the 1st step Mantoux on a specific day of December 2015 and received the 2nd step later in December 2015; 26 days post admission.

Resident #045 was admitted to the home on a specific day of January 2016 and is more than 65 years old. As per the PHU guidelined, this resident was required to have a chest x-ray for TB screening. No documentation was found to indicate the resident had received her chest x-ray as of February 12, 2016; 17 days post admission.

As such, each resident admitted to the home is not screened for tuberculosis within 14 days of admission. [s. 229. (10) 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 o ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #5: 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 has failed to ensure that any plan, policy, protocol, procedure related to the falls prevention and management program is complied with.

In accordance with O. Reg 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incident of falls and the risk of injury.

The home does have a Falls Prevention and Management Program which requires under :

"Roles and responsibilities of Team members:
Nursing (RN/RPN):
1. Completes a fall risk assessment within 24 hours of admission and when there is a significant change in health status and following a fall with significant injury
2. Initiates plan of care as per the outcome of fall risk assessment and implement strategies

Process for Falls Prevention:
Nurse :
1. Collaborate with resident/POA or SDM or family to conduct the fall risk assessment in Point click Care within 24 hours of admission and when a change in health status puts them at increased risk for falling such as:
• Significant change in health status
• Falls resulting in serious injury
2. Determine the resident's level of risk as low, medium or high. Any risk should be care planned
3. Universal Fall Prevention Interventions to be followed for all residents at low and medium risk and for residents who are high risk for falls need additional precautions (See Appendix 1)
4. Initiate a written plan of care within 24 hours of admission based on resident's assessed condition, fall, history, needs, behaviours, medications and preferences (fall risk on Point Click Care)
5. Continue to update the care plan based on the RAI-MDS assessment"

Resident #016 was admitted on a specific day of March 2015 with several diagnosis. Resident #016 fell on a specific day of December and of September 2015 and did not sustain any injury. On a specific day in August 2015, Resident #016 required analgesic for pain management post fall. A fall risk was completed on Resident #016 in January 2016 and identified the resident to be at high risk. Resident #016 health care record was reviewed, it was noted that no fall assessment was completed for August fall nor the plan of care updated to indicate the risk of fall.

Resident #017 was admitted to the home on a specific day of March 2015 with several diagnosis. Resident #017 had two falls, one in June 2015 and one in September 2015 which resulted in significant injury. Resident #017 health care record was reviewed, it was noted that no fall risk assessment were completed or plan of care was updated after both falls.

Discussion held with the Coordinator of Nursing Program (CNP) who indicated that when a fall occurs the staff are required to complete a post fall assessment and the plan of care and Kardex should be updated to indicate the risk of falls. Inspector #126 reviewed resident's #016 health care record with the CNP and who noted that there was no documentation the written plan of care or kardex indicating the fall risk level. The CNP indicated that the home is in the in process of implementing the fall program and that was an area that it needed to be worked on.

Inspector #126, interviewed Registered Practical Nurse (RPN)#111 and Personal Support Worker (PSW)#114, indicated that fall risk level was not identified in the Plan of care or in the kardex. PSW S# 114 indicated that they are informed at report if a resident had a fall and could not indicated the fall level risk for the residents.

The plans of care or the kardex were not updated indicating the risk of fall and the fall risk assessment were not completed as per the Falls Prevention and Management Program requirement. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy and procedure regarding the Skin and Wound care Program is complied with.

In accordance with O. Reg. 79/10, s. 48(1) 2. every licensee of a long-term care shall ensure that a skin and wound care program is developed and implemented in the home, to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O.Reg. 79/10, s. 50 (2) b. states every licensee of a long-term care home shall ensure that, (I) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

On February 22, 2016 Inspector #547 reviewed resident #042's health care records that identified that this resident had pressure sore requiring dressings to the back every two days. The resident began this wound on a specific day of August 2015 and measured 0.7x0.6cm. No Wound Assessment Record was ever initiated for this pressure ulcer that remains open that now measures 3 cm X 2 cm with the erythema extending approximately 6 cm on the left side of the wound and additional 3 cm on the right side of the wound.

Residents #041 and #047 were are also reviewed during this Inspection for pressure ulcers, that have both now healed, also did not have any Wound Assessment Records located in their health care records.

On February 23, 2016 Inspector #547 interviewed the Coordinator of Nursing Programs, responsible for the skin and wound program, indicated that the residents that have wounds/ulcers should be assessed using the Wound Assessment Record as per their policy and procedure.

The Coordinator of Nursing Programs provided a copy of the home's policy and procedure number: 11-03-01 titled Skin and Wound care Program for the Wound Assessment Record Procedure last revised February 2016. This policy stated the purpose for this Wound Assessment Record indicated that it provides a description of wound characteristics that identifies an improvement or deterioration in status.

This Policy further indicated that this Wound Assessment Record is to be completed on a weekly basis by all nurses who complete a wound assessment record as part of the residents' wound treatment plan.
This policies guiding principles stated:
1. The wound assessment record will:
be used for any wound requiring a treatment
be completed weekly per wound per resident
replace documenting in the resident's clinical record progress notes
be kept in the Wound Assessment Record binder until completed, then filed in the "Multi D" assessment section of the resident's chart.
. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items.

On February 8-9 and 10, 2016 inspectors #550, #126 and #573 observed the following unlabelled and used personal care items or personal aids in different resident shared bathrooms:

-bathroom T504: 1 white hair brush, 1 black hair brush, 1 black hair comb, 2 small white toothbrushes on the counter and 1 green toothbrush on top of paper towel holder
-bathroom T509: 1 electric razor and 1 toothbrush on the counter.
-bathroom B214: 2 toothbrushes and 1 bottle of antiseptic mouthwash on the counter
-bathroom B202: 1 tube of toothpaste, a bottle of mouthwash and a female deodorant stick on the counter
-bathroom B104: 1 toothbrush and 1 tube of toothpaste on counter
-bathroom L210: a male urinal

PSWs S#100, S#101 and S#102 indicated to Inspector #550 during an interview that resident's personal care items and personal aids are to be labelled with each resident's name unless the resident is in a private room.

During an interview, the Director of Care indicated to Inspector #550 that it is her expectation that all resident's personal equipment are labelled. They have introduced a new system in the home where all resident's personal care items should be kept in a labelled basket with the resident's name but are having some compliance issues with this new system.

As evidenced above, each resident of the home does not have his/her per personal items identified. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with section 73.(1)2. of the regulation in that the licensee failed to complete a review of the meal and snack times by the Residents' Council.

Inspector #138 reviewed the minutes for the monthly Resident's Council meetings from January 13, 2015, to present and noted that there was no indication that the Residents' Council had completed a review of the meal and snack times. On February 17, 2016, the Inspector spoke with the Social Service and Admission Coordinator who is assigned to assist the Residents' Council. She stated that the Food Services Manager would be invited to the Residents' Council meetings to discuss food service items including meal and snack times. That same day, the Inspector spoke with the Food Services Manager about the review of the meal and snack times with the Residents' Council and the Food Services Manager stated that no such review has been completed. [s. 73. (1) 2.]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an incident of abuse of resident #049.

On a specific day of July 2015, Registered Nurse (RN)# 133, witnessed Resident #054 charge toward Resident #049 and pushed him/her to the floor while shouting, "get the hell out of here". Resident #049 was assisted up by two staff, was physically assessed and had no injury and no complaint. (Log: #031423-15)

That morning, Resident #048 was having difficulty weight bearing on the left foot. Physician was contacted and Resident #048 was sent to the hospital for assessment. Resident #048 came back that afternoon with a fracture.

On February 26, 2015, Inspector #126 interviewed the Manager of Nursing Care Operation who indicated that the Police was not informed of this physical abuse as of this day. [s. 98.]

WN #9: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 101.(1)1. of the regulation in that the licensee failed to ensure that a written complaint by a resident to a staff member concerning the care of the resident was investigated, resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

On February 22, 2016, resident #031 reported to Inspector #138 an incident regarding unsatisfactory care provided by RN #125 that occurred approximately one month ago. Resident #031 stated that the resident sent an email to the Director of Care regarding concerns related to the incident involving RN #125 and that the email was sent a few days after the incident. Resident #031 further told the Inspector that the resident had not received any response to the sent email.

Inspector #138 spoke with the Director of Care later that day on February 22, 2016, regarding the incident reported by resident #031. The Director of Care stated that she was aware of the incident as she had received an email from Resident #031in January. The Director of Care provided a copy of the email to the Inspector and it was noted by the Inspector that the email had been sent to the Director of Care on a specific day of January 2016, and that the title of the email was "Help". The Director of Care stated to the Inspector that the resident's email did not provide her specific directions and that she had assumed that the resident had resolved any concern and, as a result, she stated that she had not completed an investigation nor responded to Resident #031's email. [s. 101. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On February 10, 2016, Inspector #573 observed on the 5th floor unit, a plastic container with medications (3 to 4 tablets) on a medication cart that was located in the hallway near the dining room. At that time, 4 residents were sitting in the dining room. No Registered Nursing (RN) was observed to be near the medications cart for approximately 5 - 8 minutes. RN Staff #109 came back to the medication cart and then went to the computer room inside the nursing station to do documentation. Inspector #573 observed RN# 109 leaving the medications cart unattended with a plastic container containing 3-4 tablets of medications and the cart was not within her field of vision.

On February 18, 2016, around 12:00, Inspector #126 observed on the 5th floor unit, a bottle of Lactulose 500ml and a vial of Glycopyrrolate 20 ml that was left on top of the medication cart that was located in the hall way near the dining room. RN #109 was observed to prepare medication for another resident and went to the resident's room leaving the medication cart unattended with the lactulose and vial on top of the medication cart.

Drugs were not stored in the medication cart that was secured and locked. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 221.(2)1. of the regulation in that the licensee failed to ensure that staff who provide direct care to residents received annual training provided for in subsection 76.(7) of the Act which includes abuse recognition and prevention.

On February 22, 2016, Inspector #138 spoke with the Director of Quality Management who is the designate lead in the home for staff education. The Inspector requested documentation related to the annual 2015 training for a casual staff member, RN #125, which included abuse recognition and prevention. The Director of Quality Management was not able to demonstrate that RN #125 received annual training in 2015 for abuse recognition and prevention and further stated to the Inspector that RN #125 had not received this specific training in 2015. [s. 221. (2)]

Issued on this 10th day of May, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126), ANANDRAJ NATARAJAN (573), JOANNE HENRIE (550), LISA KLUKE (547), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2016_285126_0003
Log No. / Registre no:	003325-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 4, 2016
Licensee / Titulaire de permis :	THE GLEBE CENTRE INCORPORATED 950 BANK STREET, OTTAWA, ON, K1S-5G6
LTC Home / Foyer de SLD :	GLEBE CENTRE 950 BANK STREET, OTTAWA, ON, K1S-5G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lawrence Grant

To THE GLEBE CENTRE INCORPORATED, 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) (a)

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 for achieving compliance with LTCHA, 227, s. 19 (1) to ensure resident are protected from abuse.
The licensee shall ensure the plan includes:
1) The development and implementation of a monitoring process to ensure:
a. The person who had reasonable grounds to suspect the abuse of a resident that resulted in harm or risk of harm immediately reports the suspicion to the Director
b. The appropriate police force is immediately notified of any alleged, suspected or witnessed in incident of abuse or neglect of a resident that the licensee suspects may constitute abuse
c. Every alleged, suspected or witnessed incident of abuse that the licensee is aware of is immediately investigated
2) The home shall develop and implement a process that will ensure that all staff and students on the unit are aware of the resident that are at high risk of physical /verbal/sexual aggression toward other residents.
3) The home shall ensure that all staff, students and volunteers understand the definitions of the different types of abuse as per the Long Term Care Home Act.
4) Develop and implement specific measures to be in place when the home abuse policy is not complied with.
5) The plan should also identify who is responsible for ensuring the completion of each item listed above.

The plan shall be submitted by fax at 613-569-9670 and sent Attention: Inspector Linda Harkins on or before March 18, 2016.

Grounds / Motifs :

1. 1. The licensee failed to ensure that resident # 051 was protected from physical abuse by Resident # 050.

In accordance with O. Regs 2. (1) (c) physical abuse is define as "the use of physical force by a resident that causes physical injury to another resident".

The home submitted a Critical Incident Report on a specific day of November, 2015 for a resident to resident abuse. On a specific day of November,2015, resident #050 had an altercation with resident #051 in the dining room in the afternoon. Resident #050 punched and hit resident #051 on the top of the head which resulted in a "skin /scratch opening".

On February 26, 2016, Inspector #126 interviewed Registered Nurse (RN) #132 via telephone. RN #132 indicated that she was doing the documentation in the alcove when he/she heard people screamed and found resident #051 right beside resident #050 and observed resident #050 hitting resident #051 on the head. RN #132 did not know how or who brought resident #051 into the dining room or how he/she got beside resident #050.At that time, resident #051 was identified as receiving palliative care and could not propel independently from the bedroom to the dining room. Resident #051 passed away 4 days after the incident not related to the injury.

On February 26, 2016, Inspector #126 interviewed four staff and one student who worked on that specific day of November 2015, on the day shift. None of them remembered who was assigned resident #051 or who brought the resident to the dining room on that day. Also staff did not remember if resident #051 was in the dining room for the whole period of 12:00-14:25 hrs.

Resident #050 was admitted to the home in 2011 with several diagnosis. Resident #050's health care record was reviewed for the period of October 2014 to the date of this inspection. There were several incidents of physical aggressive behaviors involving several residents. The following incidents were documented under behaviors notes:

1) On a specific day of October 2014 resident #050 was involved in a resident to resident abuse. A resident opened the door of resident #050, who responded by punching the resident in the face and knocking him/her on the floor. No injury

documented.
2) On a specific day of October 2014 a resident was meddling with his/her spoon and resident #050 attempted to punch the co-resident. No injury documented.
3) On a specific day of December, 2014, while resident #050 was sitting in the dining room counting his/her money/coins, punched another co-resident on the face as the resident was standing beside and talking to him/her. No injury documented.
4) On a specific day of January 2015, resident #050 was yelling at a co-resident who was wandering the unit and outside the door. The co-resident reported that resident #050 hit him/her on the face. No bruising observed.
5) On a specific day of February 2015, resident #050 slapped a co-resident as he/she tried to take a chair from the table at lunch time.
6) On a specific day of March 2015, resident #050 hit a co-resident to the right hand with a cup when both were sitting at resident #050's table. Resident #050 initiated physical and verbal aggression. No injury to co-resident.
7) On a specific day of October 2015, resident #050 hit a co-resident on the top of the head with his/her closed fist in the evening. Co-resident was sitting in a chair that resident #050 usually sits in. Resident #050 was observed to be trying to tip over the chair to remove co-resident from chair. No injury to co-resident.

Nursing staff, on the unit indicated that resident #050 is very territorial and they have to ensure that other co-resident does not get close to him/her. The plan of care dated October 2015, identifies resident #050 to be removed from public area when behavior is disruptive/ unacceptable and that he/she is very protective of the space/territorial, to ensure to redirect co-res to proper chair. It is also documented to refer to the BSO if needed for behavioral management. No documentation was found related to BSO referral or to the Psychogeriatric Team for behavior management.

On a specific day of November 2015, Resident #050 was left in the dining room, unsupervised with resident #051 who got close to him/her and was hit on the head which caused an injury. Resident # 050 was known to be territorial and reacts by physical aggression to co-residents. During the course of this inspection, resident #050 was observed on several occasions by Inspector #126 to be sitting at his/her table without any supervision and other resident wandering in the dining room. Several staff on different unit were interviewed and indicated that residents that have cognitive impairment and are exhibiting inappropriate behaviours (sexual, physical assault) have no intent of injuring the other residents.

The licensee has failed to protect resident #051 from physical abuse by resident #050 by not implementing the interventions as identified in the plan of care. (Log # 031423-15) [s. 19. (1)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2016

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 sions 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 sions 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 4th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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