Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2019	2019_800532_0011	013918-19, 013923-19, 013924-19, 013925-19	Follow up

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

NUZHAT UDDIN (532), KATHERINE ADAMSKI (753), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, and September 4, 5, 2019.

The following intakes were completed in this Follow-up (FU) inspection:

Log # 013924-19, FU to CO #003 from inspection #2019_610633_0005 related to RAI/MDS assessment;

Log # 013925-19, FU to CO #012 from inspection #2019_610633_0005 related to lift and transfers;

Log # 013923-19, FU to CO #013 from inspection #2019_610633_0005 related to skin and wound;

Log # 013918-19, FU to CO #017 from inspection #2019_610633_0005 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care Quality (DOC-Q), the Director of Care Clinical (DOC-C), the Consultants, the Administrative Supervisor (AS), Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #012	2019_610633_0005	532

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it was a condition of every licensee that the licensee must comply with every order made under this Act.

This inspection was completed as a follow up to Compliance Order (CO) #003 related to RAI-MDS assessments, CO #012 related to lifts and transfers, CO #013 related to skin and wound, and CO #017- related to plan of care. These orders were issued on June 11, 2019, during inspection 2019_610633_0005.

a) Training records for safe lifts and transfers were provided. The training records dated July 2019, included mechanical lift pre-operations, mechanical lift operation, repositioning resident in a chair and transferring. The training records showed that there were 33 staff out of 85 (38.8%) that did not receive lifts and transfer training as ordered.

A PSW stated that they had not received the safe lifts and transfer training that was offered. They stated that the last training they received was in October 2018.

The DOC stated that in total there were 85 PSWs in the home, however, 33 PSWs staff had not received the training on lifts and transfers as requested by CO # 012.

The licensee failed to provide training to all PSW staff related to lifts and transfers and to keep a written record of the education that included who completed the training, the content, and the date that staff signed off.

b) On August 20, 2019, the Director of Care Quality (DOC-Q) stated they were in the process of completing an audit schedule for skin and wound. The "Quality Management Audit Impaired Skin Integrity/Wound-Treatment Administration Record Audit" was dated July 4, 2019. No audits had been completed by the home since the compliance due date (CDD) as outlined in CO #013.

The "Quality Management Audit Impaired Skin Integrity/Wound-Treatment Administration Record Audit" did not include a process for the audit, a schedule, repositioning and the date actions were taken.

The DOC-Q stated they had now revised the audit and had developed a written process. The DOC-Q also said that a Wound Champion would be responsible for completing the

audits as of this date.

The licensee has failed to ensure that an auditing process related to skin, and wound was fully developed and implemented in the home. (633)

c) The DOC for Quality provided a blank copy of "Care Plan/RAI checklist" and a "RAI annual list 2019". The DOC-Q said that this was the tool used to audit the plan of care as identified in CO #017. They said that the audits corresponded to the completion of RAI and were done quarterly for each resident. The DOC-Q indicated that the audits were completed by the registered staff and were kept on each unit in binders.

The RAI Coordinator shared that the registered staff used the Care plan/RAI checklist to update the care plan and this was done quarterly with the MDS-RAI Schedule. They said that the care plan needed to reflect what was on the checklist before they could be locked.

Clinical Care Coordinator (CCC) stated that the Care Plan/RAI checklist was implemented by the former DOC in February 2019. This tool was used to update the plan of care and it was not created as an audit tool for CO #017. The CCC reviewed the checklist for three out of six home areas and stated that because the RAI schedule started in February 2019, there should be three quarters completed by the registered staff using the checklist. The CCC acknowledged that only one of the quarters had been completed and in some instances the checklist was blank.

The DOC acknowledged that the Care Plan/RAI checklist did not meet criteria for CO #017 as it did not include the name of the Manager or designate conducting the audit, the residents who had been audited, the results of the audit and what actions were taken in regards to the audit.

The licensee failed to ensure that an auditing process was developed and fully implemented to ensure that the plan of care for residents was being provided to the residents as specified in their plans of care, and the care provided was documented. The auditing process was to include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who were audited, the results of the audit and what actions were taken in regard to the audit results. The written audit was to be kept available in the home.

d) At the time of inspection there were 136 residents that resided at the home.

1) The "Clinical MDS Portal" reports from PointClickCare (PCC) for an identified date, documented the current outstanding RAI assessments by resident home area. The Resident Assessment Coordinator (RAI-C) reviewed the reports and confirmed that there were 34 RAI-MDS assessments that were past their assessment reference date (ARD).

On August 23, 2019, a three-resident sample in PCC was taken in relation to RAI-MDS assessments past their ARD post CDD for CO #003:

The reports showed that the identified residents' RAI-MDS were past their ARD; and RAPs and care plans had not been updated. A Personal Support Worker (PSW) and a RN both said that the care plan and kardex directed PSW staff as to the resident's individual needs for care. A RN explained that a new staff member or a staff member not familiar with the resident would not know the resident's current care needs if the resident's care plan and kardex were not based on the most recent RAI-MDS.

2) A PSW and a RN both said that an identified resident had been incontinent of urine for a number of weeks.

A RN reviewed the plan of care for the resident and agreed that their RAI-MDS had not been completed by the ARD and the resident's care plan and kardex were not up to date related to their urinary continence.

Three registered staff and the DOC-Q all stated that the barrier to completing the RAI-MDS assessments was the registered staff shortages at the home. The DOC-Q also stated that the home's processes could be improved. The DOC-Q agreed that the home had been unable to complete the required RAI-MDS assessments by their ARD date as required.

The licensee has failed to comply with the LSSA with the LHIN that stated that the licensee was required to meet the practice requirements of the RAI-MDS system. Each resident's care and service needs was not reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team to ensure that RAI-MDS tools were used correctly to produce an accurate assessment of the residents. RAPs were not generated, reviewed and completed for triggered and non-triggered clinical conditions within seven days maximum of ARD. (RAI-MDS Data-8.1(c)(ii)). (633)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).
(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).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was completed as a follow-up to CO #013 from inspection 2019_610633_0005 issued on June 11, 2019, related to skin and wound.

The plan of care for an identified resident stated that they were at risk for altered skin integrity and had areas of altered skin integrity.

The clinical record showed that a weekly assessment was not completed on the identified dates.

Registered Practical Nurses (RPNs) stated that weekly skin and wound assessments should be completed for all residents with altered skin integrity and that missed assessments should be completed as close to the original weekly date as possible.

Skin and wound assessments for the identified dates, showed that the areas of altered skin integrity had worsened.

The RPN reviewed the skin and wound assessments for the resident and stated that the assessments for the identified dates had been missed.

The licensee has failed to ensure that the resident, who exhibited altered skin integrity, was assessed at least weekly by a member of the registered nursing staff when clinically indicated. [s. 50. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the identified residents received an assessment using a clinically appropriate assessment instrument that was specifically designed for incontinence.

LTCHA 2007, c. 8, s. 6 (10)(b) states that the licensee shall ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

a) A PSW and a RN both said that an identified resident's continence status had changed. The resident had been incontinent of urine for a number of weeks. The 30-day look back report in Point of Care (POC) for the identified dates, related to "Bladder – Continence" stated that the resident was incontinent for number of days. There was no voiding diary and continence assessment in the resident's chart.

A Personal Support Worker (PSW) said they referred to the care plan and kardex for resident care information. A RN said that the Point of Care (POC) tasks, the care plan and kardex informed the PSWs of the status, level of assistance for toileting and the care needs a resident required. The resident's care plan and kardex had not been updated related to their change in urinary continence.

A RN and the Clinical Care Coordinator (CCC) both said that a three-day voiding diary and a continence assessment should be completed with a change in continence. The continence assessment was in paper form and should have been in the resident's paper chart.

b) The identified MDS assessment stated that the identified resident was incontinent of

bowel, all or almost all of the time. The previous MDS assessment stated that the resident was usually continent of bowel. The resident's care plan and kardex had not been revised to reflect the resident's decline in their bowel continence. There was no continence assessment in the resident's chart.

A RPN said that the resident had significantly declined. The resident was incontinent of bowel and required frequent cueing and physical assistance by staff for toileting. The RPN also said that they did not complete a bowel continence assessment for the resident.

A RN and the DOC-Q both said that a continence assessment should have been completed when the identified residents urinary and bowel continence changed. In addition, the residents' care plan and kardex should have been updated at that time.

c) A review of the admission MDS-RAI assessment for an identified resident stated that the resident was usually continent of bladder and that incontinent episodes occurred once a week or less.

A review of the quarterly MDS-RAI assessment indicated that the resident was occasionally incontinent of bladder, two or more times a week but not daily.

The 30-day look back report in Point of Care (POC) indicated that 30/30 days the resident was incontinent.

The RAI Coordinator stated that the resident was coded incorrectly since admission, they should have been coded as frequently incontinent but instead they were coded as usually continent. They said that the resident remained incontinent.

The Clinical Care Coordinator (CCC) said that a three-day voiding diary and a continence assessment should be completed on admission in paper form and should have been in the resident's physical chart.

A review of the physical chart by the CCC and a RPN showed that there was no documented admission voiding diary or continence assessment.

The CCC stated that the expectation would be that a new continence assessment was done with the voiding diary and documented with the current date. They indicated that this would reflect current care needs for the residents. (532)

The licensee has failed to ensure that the identified residents received a continence assessment using a clinically appropriate assessment instrument that was specifically designed for incontinence. The plan of care was not reviewed and revised when the resident's toileting care needs changed. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Findings/Faits saillants :

The licensee has failed to ensure that when the identified residents were reassessed, the plan of care was reviewed and revised when the resident's care needs changed.

This inspection was completed as a follow-up to CO #017 from inspection 2019_610633_0005 issued on June 11, 2019, related to plan of care.

a) An identified resident's plan of care under transferring directed staff to remove the assistive device post transfer.

Resident room observations identified that there was a logo posted above the resident's bed which directed staff to leave the assistive device underneath the resident.

Multiple resident observations identified that the assistive device was left under the resident while they were seated in their wheelchair.

A transfer audit tool stated to leave the assistive device under the resident as identified by the staff logo in the room.

A RPN reviewed the plan of care for the resident and acknowledged that the plan of care was not revised to indicate that the assistive device should be left under the resident as identified by the staff logo in the room.

b) A review of the admission MDS-RAI assessment for an identified resident stated that the resident was usually continent of bladder, incontinent episodes occurred once a week or less.

A review of the quarterly MDS-RAI assessment for the identified resident indicated that they were occasionally incontinent of bladder, two or more times a week but not daily.

The plan of care under bladder continence stated that the resident was usually continent of bladder (once a week or less often incontinence episodes).

The plan of care under toileting/elimination stated that the resident was independent, and no staff assistance was required.

The 30-day look back report in Point of Care (POC) related to "Bladder – Continence" stated that the resident was incontinent 30/30 days and 22/30 days the resident was incontinent either every shift or twice a shift.

The RAI Coordinator stated that the resident was coded incorrectly since admission. They should have been coded as frequently incontinent but instead they were coded as usually continent. The RAI Coordinator said that the resident remained incontinent since admission and the care plan did not reflect the resident's actual care needs.

The CCC acknowledged that the resident was coded as continent, but they should be coded occasionally incontinent, and the plan of care should have been reviewed and revised when the resident's care needs changed.

The licensee has failed ensure that the identified residents were reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary. [s. 6.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 16th day of October, 2019

[redacted]

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care 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) :	NUZHAT UDDIN (532), KATHERINE ADAMSKI (753), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2019_800532_0011
Log No. / No de registre :	013918-19, 013923-19, 013924-19, 013925-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 3, 2019
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Griffin Allen

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To Corporation of the County of Bruce, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_610633_0005, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 101. (3).

Specifically, the licensee shall ensure that:
A) Every directive issued, order made or agreement entered into under this Act is complied with.
B) All PSW staff receive education on lifts and transfers. A written record is kept of the education that includes who completed the training, the content, and the date that staff sign off.
C) An auditing process is developed and fully implemented to ensure that the plan of care for residents is being provided to the residents as specified in their plans of care, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regard to the audit results. The written audit must be kept available in the home.
D) They comply with the LSSA with the LHIN that states that the licensee is required to meet the practice requirements of the RAI-MDS system. Each resident's care and service needs are to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team to ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the residents. RAPs are generated, reviewed and completed for triggered and non-triggered clinical conditions within seven days maximum of ARD.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the LTCHA: it was a condition of every licensee that the licensee must comply with every order made under this Act.

a) On June 11, 2019, the following compliance order (CO) #012 from inspection #2019_610633_0005 made under O. Reg. 79/10, s. 36 was issued:

A) That all staff use safe transferring and positioning devices or techniques when assisting an identified resident and all other residents.

B) That all PSW staff receive education on transfers and lifts. A written record must be kept of the education that includes who completed the training, the content, and date staff sign off.

The compliance due date was July 19, 2019.

The licensee completed step A) but failed to complete step B) of CO #012.

Training records for safe lifts and transfers were provided. The training records dated July 2019, included mechanical lift pre-operations, mechanical lift operation, repositioning resident in a chair and transferring. The training records showed that there were 33 staff out of 85 (38.8%) that did not receive lifts and transfer training as ordered.

A PSW stated that they had not received the safe lifts and transfer training that was offered. They stated that the last training they received was in October 2018.

The DOC stated that in total there were 85 PSWs in the home, however, 33 PSWs staff had not received the training on lifts and transfers as requested by CO # 012.

The licensee failed to complete step B) of CO #012 to provide training to all PSW staff related to lifts and transfers and that a written record must be kept of the education that includes who completed the training, the content, and the date that staff signed off. (532)

2. On June 11, 2019, the following CO #013 from inspection #2019_610633_0005 made under O.Reg.79/10, s. 50(2)(b)(i)(ii)(iv) was issued.

A) Designate a Wound Care Lead at the home.

B) Ensure that three identified residents, and any other resident, exhibiting altered skin integrity based on the definition for "altered skin integrity" in O. Reg. 79/10, s. 50 (3), including skin breakdown, pressure ulcers, skin tears or wounds:
1) 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.
2) Is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
3) Is repositioned every two hours or more frequently as required including while asleep if clinically indicated.
4) 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.

C) Ensure that an auditing process is developed and fully implemented related to RD referrals, repositioning and weekly skin and wound assessments. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

The compliance due date (CDD) was July 19, 2019.

The licensee completed steps A) B) 1, 3, and 4 but failed to complete step C) of CO #013.

On August 20, 2019, the Director of Care Quality (DOC-Q) stated they were in the process of completing an audit schedule for skin and wound. The “Quality Management Audit Impaired Skin Integrity/Wound-Treatment Administration Record Audit” was dated July 4, 2019. No audits had been completed by the

home since the compliance due date (CDD) as outlined in CO #013.

The "Quality Management Audit Impaired Skin Integrity/Wound-Treatment Administration Record Audit" did not include a process for the audit, a schedule, repositioning and the date actions were taken.

The DOC-Q stated they had now revised the audit and had developed a written process. The DOC-Q also said that a Wound Champion would be responsible for completing the audits as of this date.

The licensee has failed to complete step C) of CO #013 to ensure that an auditing process related to skin and wound was fully developed and implemented in the home. (633)

3. 1) At the time of inspection there were 136 residents that resided at the home.

The "Clinical MDS Portal" reports from PointClickCare (PCC) for an identified date, documented the current outstanding RAI assessments by resident home area. The Resident Assessment Coordinator (RAI-C) reviewed the reports and confirmed that there were 34 RAI-MDS assessments that were past their assessment reference date (ARD).

On August 23, 2019, a three-resident sample in PCC was taken in relation to RAI-MDS assessments past their ARD post CDD for CO #003:

The reports showed that the identified residents' RAI-MDS were past their ARD; and RAPs and care plans had not been updated. A Personal Support Worker (PSW) and a RN both said that the care plan and kardex directed PSW staff as to the resident's individual needs for care. A RN explained that a new staff member or a staff member not familiar with the resident would not know the resident's current care needs if the resident's care plan and kardex were not based on the most recent RAI-MDS.

2) A PSW and a RN both said that an identified resident had been incontinent of urine for a number of weeks.

A RN reviewed the plan of care for the resident and agreed that their RAI-MDS

had not been completed by the ARD and the resident's care plan and kardex were not up to date related to their urinary continence.

Three registered staff and the DOC-Q all stated that the barrier to completing the RAI-MDS assessments was the registered staff shortages at the home. The DOC-Q also stated that the home's processes could be improved. The DOC-Q agreed that the home had been unable to complete the required RAI-MDS assessments by their ARD date as required.

The licensee has failed to comply with the LSSA with the LHIN that stated that the licensee was required to meet the practice requirements of the RAI-MDS system. Each resident's care and service needs was not reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team to ensure that RAI-MDS tools were used correctly to produce an accurate assessment of the residents. RAPs were not generated, reviewed and completed for triggered and non-triggered clinical conditions within seven days maximum of ARD. (RAI-MDS Data –8.1(c)(ii)).
(633)

4. On June 11, 2019, the following CO #017 from inspection # 019_610633_0005 made under O. Reg. 79/10, s. 6 was issued:

The licensee must be compliant with s. 6. of the LTCHA.

Specifically, the licensee must:

A) Review all resident transfer logos to ensure they provide clear directions to staff. Maintain documentation of the review that includes who completed the review, the date of the review and the changes made, and the date changes were implemented.

B) Ensure that the identified resident and all other residents, are reassessed and the plan of care is reviewed and revised when their continence needs changes.

C) Ensure that the plan of care for the identified resident and all other residents, is followed related to skin and wound care. Specific to the identified residents' assistive device are in place as per their plan of care.

D) Ensure that the plan of care for the identified residents is followed, and the care is documented related to continence care.

E) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents is being provided to the residents as specified in their plans of care, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regard to the audit results. The written audit must be kept available in the home.

The compliance due date was July 19, 2019.

The licensee completed step A), C) and D) but failed to complete step E) of CO #017.

The licensee also failed to complete step B). This area of non-compliance has been issued under s. 6.

The DOC for Quality provided a blank copy of "Care Plan/RAI checklist" and a "RAI annual list 2019". The DOC-Q said that this was the tool used to audit the plan of care as identified in CO #017. They said that the audits corresponded to the completion of RAI and were done quarterly for each resident. The DOC-Q indicated that the audits were completed by the registered staff and were kept on each unit in binders.

The RAI Coordinator shared that the registered staff used the Care plan/RAI checklist to update the care plan and this was done quarterly with the MDS-RAI Schedule. They said that the care plan needed to reflect what was on the checklist before they could be locked.

Clinical Care Coordinator (CCC) stated that the Care Plan/RAI checklist was implemented by the former DOC in February 2019. This tool was used to update the plan of care and it was not created as an audit tool for CO #017. The CCC reviewed the checklist for three out of six home areas and stated that because the RAI schedule started in February 2019, there should be three quarters

completed by the registered staff using the checklist. The CCC acknowledged that only one of the quarters had been completed and in some instances the checklist was blank.

The DOC acknowledged that the Care Plan/RAI checklist did not meet criteria for CO #017 as it did not include the name of the Manager or designate conducting the audit, the residents who had been audited, the results of the audit and what actions were taken in regards to the audit.

The licensee failed to complete step E) of CO #017 ensure that an auditing process was developed and fully implemented to ensure that the plan of care for residents was being provided to the residents as specified in their plans of care, and the care provided was documented. The auditing process was to include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who were audited, the results of the audit and what actions were taken in regard to the audit results. The written audit was to be kept available in the home.

The severity of the issue was a level 2, minimal harm/ risk and the scope of the issue was a level 3 widespread. The home had a level 5 compliance history that included:

-CO from inspection 2019_610633_0005 issued June 11, 2019. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_610633_0005, CO #013;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 50. (2)(b)(i)(ii)(iv).

Specifically, the licensee must:

A) Ensure that the identified resident and any other resident, exhibiting altered skin integrity based on the definition for "altered skin integrity" in O. Reg. 79/10, s. 50 (3), including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

B) Ensure that an auditing process is developed and fully implemented related to weekly skin and wound assessments. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #013 from inspection 2019_610633_0005 issued on June 11, 2019, with a compliance due date (CDD) of July 19, 2019.

The licensee must be compliant with O. Reg. 79/10, s. 50. (2)(b)(i)(ii)(iv).

Specifically, the licensee must:

A) Designate a Wound Care Lead at the home.

B) Ensure that identified residents, and any other resident, exhibiting altered skin integrity based on the definition for "altered skin integrity" in O. Reg. 79/10, s. 50 (3), including skin breakdown, pressure ulcers, skin tears or wounds:

1) 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.
2) Is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

3) Is repositioned every two hours or more frequently as required including while asleep if clinically indicated.
4) 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.

C) Ensure that an auditing process is developed and fully implemented related to RD referrals, repositioning and weekly skin and wound assessments. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

The licensee completed step A and B (1)(3)(4) in CO #013.

The licensee failed to complete step B (2) related to reassessing altered skin integrity at least weekly by a member of the registered nursing staff when clinically indicated.

The licensee also failed to complete step C). This area of non-compliance has been issued under s. 101. (3).

This inspection was completed as a follow-up to CO #013 from inspection 2019_610633_0005 issued on June 11, 2019, related to skin and wound.

The plan of care for an identified resident stated that they were at risk for altered skin integrity and had areas of altered skin integrity.

The clinical record showed that a weekly assessment was not completed on the identified dates.

Registered Practical Nurses (RPNs) stated that weekly skin and wound assessments should be completed for all residents with altered skin integrity and that missed assessments should be completed as close to the original weekly date as possible.

Skin and wound assessments for the identified dates, showed that the areas of

altered skin integrity had worsened.

The RPN reviewed the skin and wound assessments for the resident and stated that the assessments for the identified dates had been missed.

The licensee has failed to ensure that the identified resident, who exhibited altered skin integrity, was assessed at least weekly by a member of the registered nursing staff when clinically indicated.

The severity of the issue was a level 3, actual harm/risk and the scope of the issue was a level 3 widespread. The home had a level 5 compliance history that included:

-DR/CO from inspection 2019_610633_0005 issued June 11, 2019;
-CO from inspection 2018_580568-0014 issued October 26, 2018. (753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 51. (2)

Specifically, the licensee shall ensure that:
A) All identified residents and all residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of continence.
B) The home's continence policy includes:
i) a specific procedure or protocol for the assessment of bowel and bladder continence
ii) references both the bladder and bowel continence assessment tools that registered staff are to use.
C) Training is provided in person to all registered staff and includes:
i) the home's revised continence policy, bowel and bladder continence assessment tools and how to complete and document the assessments,
ii) the process as to where the new continence assessments can be located,
iii) a written record of the education that includes who completed the training, the content, and the date that staff signed off.

Grounds / Motifs :

1. The licensee has failed to ensure that the identified residents received an assessment using a clinically appropriate assessment instrument that was specifically designed for incontinence.

LTCHA 2007, c. 8, s. 6 (10)(b) states that the licensee shall ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

A) A PSW and a RN both said that an identified resident's continence status had changed. The resident had been incontinent of urine for a number of weeks. The 30-day look back report in Point of Care (POC) for the identified dates, related to "Bladder – Continence" stated that the resident was incontinent for number of days. There was no voiding diary and continence assessment in the resident's chart.

A Personal Support Worker (PSW) said they referred to the care plan and kardex for resident care information. A RN said that the Point of Care (POC) tasks, the care plan and kardex informed the PSWs of the status, level of assistance for toileting and the care needs a resident required. The resident's care plan and kardex had not been updated related to their change in urinary continence.

A RN and the Clinical Care Coordinator (CCC) both said that a three-day voiding diary and a continence assessment should be completed with a change in continence. The continence assessment was in paper form and should have been in the resident's paper chart.

B) The identified MDS assessment stated that the identified resident was incontinent of bowel, all or almost all of the time. The previous MDS assessment stated that the resident was usually continent of bowel. The resident's care plan and kardex had not been revised to reflect the resident's decline in their bowel continence. There was no continence assessment in the resident's chart.

A RPN said that the resident had significantly declined. The resident was incontinent of bowel and required frequent cueing and physical assistance by staff for toileting. The RPN also said that they did not complete a bowel continence assessment for the resident.

A RN and the DOC-Q both said that a continence assessment should have been completed when the identified residents urinary and bowel continence changed. In addition, the residents' care plan and kardex should have been updated at that time.

The licensee has failed to ensure that the identified resident received a continence assessment using a clinically appropriate assessment instrument that was specifically designed for incontinence. The plan of care was not reviewed and revised when the resident's toileting care needs changed. (633)

2. A review of the admission MDS-RAI assessment for an identified resident stated that the resident was usually continent of bladder and that incontinent episodes occurred once a week or less.

A review of the quarterly MDS-RAI assessment indicated that the resident was occasionally incontinent of bladder, two or more times a week but not daily.

The 30-day look back report in Point of Care (POC) indicated that 30/30 days the resident was incontinent.

The RAI Coordinator stated that the resident was coded incorrectly since admission, they should have been coded as frequently incontinent but instead they were coded as usually continent. They said that the resident remained incontinent.

The Clinical Care Coordinator (CCC) said that a three-day voiding diary and a continence assessment should be completed on admission in paper form and should have been in the resident's physical chart.

A review of the physical chart by the CCC and a RPN showed that there was no documented admission voiding diary or continence assessment.

The CCC stated that the expectation would be that a new continence assessment was done with the voiding diary and documented with the current date. They indicated that this would reflect current care needs for the residents

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

The severity of the issue was a level 2, minimal harm/ risk and the scope of the issue was a level 3 widespread. The home had a level 3 compliance history that included:

-WN from inspection 2019_610633_0005 issued June 11, 2019.
(532)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 16, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2019_610633_0005, CO #017;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 6.

Specifically, the licensee shall ensure that:

A) Ensure that the identified residents and all other residents, are reassessed and the plan of care is reviewed and revised when their continence needs changes.

B) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents is being provided to the residents as specified in their plans of care, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

Grounds / Motifs :

1. The licensee has failed to comply with the following Compliance Order #017 from inspection 2019_610633_0005 issued on June 11, 2019, with a compliance date of July 19, 2019.

The licensee must be compliant with O.Reg. 79/10, s.6.

Specifically, the licensee shall ensure that:

A) Review all resident transfer logos to ensure they provide clear directions to staff. Maintain documentation of the review that includes who completed the

review, the date of the review and the changes made and the date changes were implemented.

B) Ensure that the identified resident, and all residents, are reassessed and the plan of care is reviewed and revised when their continence needs changes.

C) Ensure that the plan of care for the identified resident, and all residents, is followed related to skin and wound care. Specific to the identified resident that DermaSaver protectors are in place as per their plan of care.

D) Ensure that the plan of care for the identified resident is followed, and the care is documented related to continence care.

E) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents is being provided to the residents as specified in their plans of care, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

The licensee completed step A), C) and D) in CO #017.

The licensee failed to complete step B) related to ensuring that all resident's, were reassessed and the plan of care was reviewed and revised when their continence needs changed.

The licensee also failed to complete step E. This area of non-compliance has been issued under s. 101. (3).

a) An identified resident's plan of care under transferring directed staff to remove the assistive device post transfer.

Resident room observations identified that there was a logo posted above the resident's bed which directed staff to leave the assistive device underneath the resident.

Multiple resident observations identified that the assistive device was left under the resident while they were seated in their wheelchair.

A transfer audit tool stated to leave the assistive device under the resident as identified by the staff logo in the room.

A RPN reviewed the plan of care for the resident and acknowledged that the plan of care was not revised to indicate that the assistive device should be left under the resident as identified by the staff logo in the room.

b) A review of the admission MDS-RAI assessment for an identified resident stated that the resident was usually continent of bladder, incontinent episodes occurred once a week or less.

A review of the quarterly MDS-RAI assessment for the identified resident indicated that they were occasionally incontinent of bladder, two or more times a week but not daily.

The plan of care under bladder continence stated that the resident was usually continent of bladder (once a week or less often incontinence episodes).

The plan of care under toileting/elimination stated that the resident was independent, and no staff assistance was required.

The 30-day look back report in Point of Care (POC) related to "Bladder – Continence" stated that the resident was incontinent 30/30 days and 22/30 days the resident was incontinent either every shift or twice a shift.

The RAI Coordinator stated that the resident was coded incorrectly since admission. They should have been coded as frequently incontinent but instead they were coded as usually continent. The RAI Coordinator said that the resident remained incontinent since admission and the care plan did not reflect the resident's actual care needs.

The CCC acknowledged that the resident was coded as continent, but they should be coded occasionally incontinent, and the plan of care should have been reviewed and revised when the resident's care needs changed.

The licensee has failed ensure that identified residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

The severity of the issue was a level 2, minimal harm/ risk and the scope of the issue was a level 1 isolated. The home had a level 5 compliance history that included:

-CO from inspection 2019_610633_0005 issued June 11, 2019;
-CO from inspection 2018_580568-0014 issued October 26, 2018;
-VPC from inspection 2017-610633-0023 issued January 9, 2018;
-VPC from inspection 2016-260521-0039 issued September 28, 2016. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 3rd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : Central West Service Area Office