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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 01, 2014;	2014_157210_0017 (A1)	T-10-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CAREFREE LODGE
306 FINCH AVENUE EAST NORTH YORK ON M2N 4S5

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

SLAVICA VUCKO (210) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 1, 2, 3, 6, 7, 8, 9,10, 14, and 15, 2014.

The inspection was conducted concurrently with critical incident (T-611-13), follow up inspection T-739-14, and findings from these are contained in this report.

During the course of the inspection, the inspector(s) spoke with registered nurses (RN),registered practical nurse (RPN), RAI Coordinator, practical care aid (PCA), director of nursing (DON), administrator, recreation service assistant, nurse managers (NM), environmental supervisor, registered dietitian (RD), program manager, physiotherapist (PT), Resident's Council's president, family council's president, family members, resident council president, housekeeping staff.

During the course of the inspection, the inspector(s) toured the resident home areas, observed medication administration, resident to staff interactions, resident to resident interactions, provision of care, dining and snack services, reviewed clinical and home records, Residents' and Family Council minutes, menus, staff training records, staff schedules, home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

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

Recreation and Social Activities

Residents' Council

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
18 WN(s)
1 VPC(s)
1 CO(s)
0 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:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2014_159178_0005	210
LTCHA, 2007 s. 19. (1)	CO #001	2014_159178_0005	210
LTCHA, 2007 s. 6. (7)	CO #003	2014_159178_0005	210

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

An inspection has been conducted on March 14, 2014, and a compliance order has been issued for O. Reg. 79/10, s. 15 (1) with a compliance date for July 31, 2014.

Interview with the DON and the administrator indicated that the home had conducted a bed rail audit, and the bed system was evaluated on September 24, 2014, by staff. The home uses a mattress/bed/side rail audit tool to record the room and bed number, type of bed, side rail length, type of mattress, length, width, risk, and sticker in place.

According to the Health Canada's best practice document for bed system evaluation, appropriate method and measuring tools should be used during the evaluation to determine the potential risks for resident entrapment.

Record review and staff interview confirmed that resident #3 and #7 were assessed to use a quarter bed rail for bed mobility, repositioning or transfer. Record review of the audit tool indicated that the bed system evaluation on September 24, 2014, was incomplete.

Interview with the supervisor of building services indicated that he/she conducted the bed system evaluation on September 24, 2014. During the evaluation, the staff tested the bed remote for proper functioning; observed the mattress size for proper fitting and the head board and foot board for proper installation; checked the bed rail for proper functioning. The staff confirmed that he/she did not measure any dimension of the entrapment zones but he/she only observed the gaps between the bed rail and the mattress and the bed rail and bed frame.

The supervisor of building services was not able to demonstrate that the home evaluated all potential entrapment zones for the risk of entrapment according to the Health Canada's best practice document for bed system evaluation. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy Skin Care and Wound Management is in compliance with applicable requirements under the Act.

Review of the home's policy Skin Care and Wound Management, published October 1, 2014, in the section protocols for treatment of stage 1 pressure ulcer states the following: stage 1 pressure ulcer is characterized by a reddening of the skin's surface that does not disappear within 20 minutes, staff to report the changes in skin condition, assess skin condition and check that Braden Scale is current with appropriate interventions to reduce identified risk factors, turn the resident using small position changes of 30 degrees to reduce pressure, follow turning schedule as per care plan, mobilize the resident on day and evening shift as appropriate, transfer and position correctly to prevent shearing and friction, sitting time may require reduction if the buttocks, sacrum or ischeal areas are involved, refer to occupational therapist (OT) for positioning and seating assessment.

The home's policy Skin Care and Wound Management is not in compliance with

applicable requirements under the Long Term Care Homes (LTCH) Act, Ontario Regulation, r.50 (2) (b) (iii) that states: a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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. [s. 8. (1) (a)]

2. The licensee has failed to ensure that the policy Skin Care and Wound Management is complied with.

Review of the home's policy Skin Care and Wound Prevention and Management, Algorithm for management of residents at risk for pressure ulcer occurrence, published October 1, 2010, stated that if the resident has a pressure ulcer(s), wounds, and poor skin integrity and the wound is healed/remodeled staff to reassess wound weekly for four weeks by using the wound assessment tool, resume Braden Score assessment quarterly, check the healed wound daily for two weeks and then weekly for four weeks, record/initial indicating healed wound checked in the treatment treatment administration records (TARs).

Review of the clinical record for resident #1 and interview with an identified registered nursing staff and the skin care coordinator indicated the pressure ulcer stage 2 healed at the end of 2014, the wound re-opened again two months later, and it is still present at the time of the inspection.

Review of the weekly skin assessment records and interview with registered nursing staff confirmed the wound was not reassessed weekly for four weeks after healing at the end of 2014 using the wound assessment tool, the healed wound was not checked daily for two weeks and then weekly for four weeks and recorded/initialed indicating healed wound checked in the treatment TARS. [s. 8. (1) (b)]

3. Review of the home's policy Skin Care and Wound Prevention and Management, Algorithm for management of residents at risk for pressure ulcer occurrence, published October 1, 2010, stated if the resident has a pressure ulcer Stage 2 or greater the resident to be referred to PT, OT, RD, Medical Doctor (MD) and Skin Care Coordinator (SCC).

Review of the clinical record, interviews with an identified registered nursing staff and PT indicated resident #1 had a stage 2 ulcer on the left groin since February 14, 2014, it is not healed at the time of the inspection, and no referral was sent to PT.

Review of the clinical record and interview with PT confirmed that the resident was not referred to PT for assessment according to the policy. [s. 8. (1) (b)]

4. Review of the policy Skin Care and Wound Prevention and Management, Algorithm for management of residents at risk for pressure ulcer occurrence, published October 1, 2010, stated if the resident has a Stage 2 pressure ulcer the affected area to be cleansed and covered with a dressing/treatment as per the physician's order.

Review of the clinical record indicated during the first quarter in 2014, resident #1 had a stage 2 pressure ulcer on one area of the body and the registered nursing staff wrote in progress notes and treatment administration record (TAR) the wound to be cleansed with Bethadine and covered with non-stick dressing two times a day without obtaining a physician's order as per the policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy Skin Care and Wound Management is in compliance with applicable requirements under the Act, and it is not complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

Findings/Faits saillants :

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

Review of the written plan of care for resident #1 in relation to skin and wound care indicated the resident is at high risk for pressure ulcers, and the interventions were: pulsating bed to prevent skin ulcer, skin to be checked for redness, bruises or skin breakdown and reported to RN, RPN, MD, turn and reposition the resident as needed per shift, reposition the resident at a 30 degrees angle in bed and chair, when moving resident, lift or roll resident's body to avoid shearing of skin using lifting sheet.

Interview with the registered nursing staff indicated the resident had indwelling catheter in place. Interview with a PCA indicated she/he empties the catheter bag every shift as needed.

The written plan of care did not provide any direction in regards to the catheter. [s. 6. (1) (c)]

2. Review of the written plan of care in relation to continence care for resident #9 indicated the resident to be assisted with toileting according to scheduled toileting plan, assisted with toileting after meals (PC) and before going to bed (HS) urinal.

Interview with a PCA indicated that PC means that the resident should be assisted with toileting between meals. Interview with registered nursing staff indicated that PC means that the resident has to be assisted with toileting after meals. Interview with RAI Coordinator indicated that for a resident to be on a scheduled toileting plan, it has to be a documentation with a schedule when the resident should be assisted with toileting. This is part of the restorative care program and includes written plan of care for resident #9 which needed to be updated. Interview with the resident indicated that the resident is using the urinal at night.

Review of the written plan of care and interview with an identified staff indicated the written plan of care did not provide clear direction to staff in relation to toileting schedule. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care is based on the resident's preferences.

In an interview, the resident's SDM indicated she requested that resident #6 be dressed in layers, and as reminder, she placed a sign in the resident's room. She also indicated that when the sign was missing the resident was not dressed in layers.

In an interview an identified PCA indicated that she was not aware of the preference of the resident to be dressed in layers and the registered nursing staff confirmed that the information has not been added in the plan of care.

Record review revealed that the preferences of the resident to be dressed in layers was not included in the plan of care. [s. 6. (2)]

4. Resident interview indicated that she is not comfortable with an identified nursing staff following an alleged emotional abuse and told the nurse manager she did not want that staff member to provide care to her.

Review of the investigation notes and interview with a nurse manager confirmed that the identified nursing staff will not be assigned to resident #10.

Interview with the identified nursing staff revealed that since the incident on September 15, 2014, she had provided care to resident #10 in three different occasions, the last quarter in 2014.

The care resident #10 received was not according to her expressed preference. [s. 6. (2)]

5. The licensee has failed to ensure that the staff and others who provide direct care to resident #4 have convenient and immediate access to it.

A review of the plan of care for resident #4 indicated that the resident is at high risk for falls and should be observed hourly by staff for safety and needs assistance when the resident is in room and in bed at night. Review of resident's #4's written care plan binder that PCAs had access to and interview with a PCA confirmed that it did not include copies of the plan of care for high risk for falls of the resident.

Interview with two PCAs confirmed that they were not aware of the requirement to observe the resident every hour when the resident was in the room and in the bed at night. Staff confirmed that the resident was observed only when staff would pass by the resident. Interview with an identified PCA indicated that he/she has access to the paper copy of the care plan that is located in the binder at the nursing station. He/she confirmed that the pages of the falls care plan were missing, therefore he/she did not have convenient and immediate access to the plan of care related to resident's high risks for falls. [s. 6. (8)]

6. The licensee has failed to ensure that the staff and others who provide direct care to resident #7 are kept aware of the contents of the resident's plan of care.

A review of the written plan of care for resident #7 indicated the resident is at high risk for fall and should be observed hourly by staff for safety and need for assistance.

Interview with a registered nursing staff and a PCA confirmed that they observed the resident for safety but not on regular basis, every hour, and they were not aware of the written plan of care indicating staff should observe resident hourly for safety and need for assistance. [s. 6. (8)]

7. The licensee has failed to ensure that the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of the resident #9's written plan of care indicated that staff should sit with the resident at the table throughout the meal in order to remind him/her to eat because the resident loses concentration.

On October 10, 14 and 15, 2014, the resident was observed eating lunch in the ground floor dining room, staff was not observed sitting with him/her at any time while he/she was eating.

Staff interview indicated that resident #9 is provided sufficient time to eat independently; however, he/she does not need staff to sit with him/her throughout the meal. Interview with the in-charge nurse confirmed that the resident is an independent eater and the plan of care was not updated to reflect the resident needs. [s. 6. (10) (b)]

8. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective.

Review of the clinical record and interview with the registered nursing staff and skin care coordinator indicated resident #1 had a stage 2 pressure ulcer that healed at the end of 2013, and reopened two months later. On March 12, 2014, a device was applied to manage the incontinence and promote wound healing. The efficacy of the device was assessed in four weeks according to the physician's order, and an antibiotic was ordered to treat the wound infection.

Interview with registered nursing staff and review of the weekly skin assessments, the wound is still stage 2, not healed and it is still present at the time of inspection.

Review of the clinical record and interview with the registered nursing staff confirmed that the plan of care in regards to the efficacy of the device use was not reviewed and revised from April 12, 2014, till October 6, 2014. [s. 6. (10) (c)]

9. The licensee has failed to ensure that the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Review of the clinical record (Resident assessment instrument (RAI)quarterly assessments) from July 25, 2014, indicated resident #1 had impaired vision with no vision appliances. Interview with the RAI Coordinator indicated the resident assessment protocol (RAP) from August 2013 stated that the resident had to be referred to an eye specialist. The written plan of care and interventions for impaired vision were inactivated therefore inaccessible to staff. Interview with a PSW indicated she was not aware that the resident had impaired vision.

Interview with RAI coordinator and review of the clinical record indicated the written plan of care did not include the section for (impaired) vision with interventions. [s. 6. (10) (c)]

10. Review of the written plan of care for resident #4 reviewed on April 15, 2013, and interview with RAI coordinator indicated the resident had impaired vision and used to wear glasses but not any more, and the vision part of the written plan of care was inactivated therefore the direct care staff was not able to access it. Interview with registered nursing staff and a PCA indicated that the resident used to wear glasses and was interested in reading the newspaper but not any more since last year.

Interview with RAI coordinator and review of the clinical record indicated the written plan of care did not include the section for (impaired) vision with interventions. [s. 6. (10) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with resident #10 indicated that on September 15, 2014, an identified nursing staff commented to him/her in different occasions throughout the shift that the facial care was not appropriate. The resident indicated that he/her felt awful because the staff's comment broke his/her heart and he/she would never forget what happened that evening. He/she hoped that the identified staff member would never give him/her a shower again.

Interview with an identified nursing staff indicated before dinner the resident asked for opinion about the facial care done by a volunteer and he/she answered that it looked good but it would look better if it was done differently. During the evening care the identified nursing staff tried to clean the resident's face but it was very hard. During shower, the staff member repeatedly washed the resident face with water and soap and he/she then told the resident not to have such an intensive facial treatment next time. The identified staff member confirmed that at that moment the resident reacted, started shouting, and became very upset.

According to the home's policy, the definition of emotional abuse is a remark that is performed by anyone other than the resident.

Interview with the NM and administrator indicated that the incident was considered as a concern that was investigated. It was concluded that it was a miscommunication between the resident and the staff member, and confirmed that the incident was not reported to the Director under the LTC homes Act.

Interview with the administrator indicated that the home has one "issues" record and one "complaints" record. The issues do not get reported to the Director but the complaints do. This incident was recorded as an issue of miscommunication and confirmed that it was not reported to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's vision.

Review of the clinical record (RAI MDS record) indicated resident #1, #4 and #6 had impaired vision and did not use vision appliances.

Interview with the registered nursing staff and NM indicated the residents were not referred to an eye specialist for eye examination. [s. 26. (3) 3.]

2. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Review of the resident #1's clinical record and interview with the registered nursing staff indicated the resident was at high risk for pressure ulcer occurrence. The resident had a pressure ulcer in 2013 that healed at the end of 2013, but reoccurred two months later. On March 12, 2014, a different approach was initiated to manage the continence and help heal the stage 2 pressure ulcer. Review of the weekly skin assessments and interview with registered nursing staff indicated the wound is still not healed.

According to the skin care and wound prevention and management policy the skin care coordinator should liaise with the community resources to provide the best possible care to a resident with a wound. The community service roles and responsibilities are described as performing contracted wound assessment and treatment services through skin and wound specialists. According to the description of the role of the skin care co-ordinator the duties are receiving referrals from unit care teams for all non-healing and complex wounds, reviewing the documentation, care plans and health records and collaborating with the interdisciplinary team to discuss progress and outcomes, complete the assessment and contact the community resources as needed.

Interview with registered nursing staff indicated he/she was not familiar who the skin care coordinator was and that the home used to use services from St. Elizabeth health care for skin and wound care but not anymore. Interview with NM who was appointed to be a skin care coordinator two months ago indicated that the home utilizes the nurse led outreach team from Humber River Regional Hospital for assessment and follow up on wound care and referred to the flipping binder at the nursing station.

The resident was not referred for a wound interdisciplinary assessment to the resources that were available. [s. 26. (3) 15.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Review of the clinical record (flow sheets for personal care-mouth care provided) for resident #6 indicated on October 1, 2, 3, 6 and 7, October, 2014, there was no signature that the mouth care was given in the morning. Interview with a day PCA indicated the resident is total care, is being assisted by night staff to be transferred into the wheelchair and it is expected that the night shift staff does the mouth care. That is why it is not being signed by the day shift staff as performed. Interview with a night shift PCA indicated that on October 6 and 7, 2014, he/she assisted the resident with dressing, peri-care and transferring into the wheelchair but not with grooming, or mouth care because those responsibilities are for the day shift staff.

Review of the clinical record and interview with staff confirmed that resident #6 did not receive mouth care in the mornings. [s. 34. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the home's policy falls prevention and management, number RC-0518-21, published on October 2013, indicated the staff should use a post fall assessment huddle form to assess residents after each fall.

Record review and interview with registered nursing staff indicated resident #21 was identified at risk for falls. On October 8, 2013, the resident fell in the hallway after lunch and was sent to hospital.

Record review and interview with registered nursing staff confirmed that the post fall assessment huddle for the fall on October 8, 2013 was not completed. [s. 49. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers, received 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.

Review of the clinical record for resident #1 and interview with registered nursing staff indicated the resident was at high risk for skin breakdown and had a pressure ulcer stage 2 on the left groin (ischeal ulcer) that healed at the end of 2013. Two months later, the resident sustained a pressure ulcer stage 2 again on the same area and the weekly wound assessments were initiated and documented on the ulcer/wound assessment record. According to the policy for skin care and wound prevention and management the skin assessment has to be performed and documented on the " Head to toe skin assessment" form.

Interview with the registered nursing staff confirmed that the head to toe assessment form could not be located in the resident chart. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Review of the clinical record and interview with the registered nursing staff and RD indicated when resident #1 exhibited pressure ulcer stage 2 on February 14, 2014, a referral had not been sent to the RD in order to assess the pressure ulcer and make any changes to the plan of care related to nutrition and hydration. [s. 50. (2) (b) (iii)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Residents' Council's meeting minutes dated August 28, 2014, revealed that a suggestion was raised by the council regarding a safety concern (residents in wheelchairs not to be placed in the middle of the hallway while the nurse is giving medications) and no response was recorded in the minutes.

Interview with the Residents' Council's president indicated that they did not receive any clear answer during the meeting, and they have not received any written response from the home after the meeting.

Interview with the programs and services manager confirmed that no response in writing was given to the Residents' Council within 10 days of receiving the council advice related to the concern and recommendation. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Record review revealed and interview with the lead of the education program confirmed that 27 per cent of full-time and part-time staff did not complete the training on the home's zero tolerance of abuse and neglect in 2013. [s. 76. (4)]

2. The licensee has failed to ensure that all direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations.

Review of the education records revealed that the home did not provide training in least restraints to 52 per cent direct care staff in 2013. Interview with the manager of programs and services and DON confirmed that not all direct care staff were provided training in 2013. [s. 76. (7) 4.]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation performed on October 1, 2014, at 10:00 a.m., indicated copies of the following inspection reports from the past two years were not posted:
- 2014_159178_0005 issued on June 9, 2014
- 2013_162109_0032 issued on December 6, 2013
- 2013_158101_0034 issued on July 15, 2013
- 2012_157322_0002 issued on October 9, 2012.

Observation performed on October 1, 2014, indicated that the home posted the copies of inspection reports 2014_159178_0005 and 2013_162109_0032 on the information board in the main floor hallway. There was no indication on the board that would direct residents and visitors where to locate the other inspection reports.

Observation and interview with the administrator confirmed that the copies of the other two inspection reports were kept in the public information resource binder (on the visitor's sign-in table) located at the front entrance, and they were not posted on the board with the other reports. [s. 79. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in acting on the satisfaction surveys results.

A review of Residents' Council meeting minutes dated January 30, 2014, indicated that the 2013 satisfaction survey was completed and the home would go over the responses and share the home's plan about the survey results with the council. Subsequent council meetings were held on March 27, and August 28, 2014, and the meeting minutes have not indicated sharing of any survey results with the council.

Interview with the Residents' Council's president and the programs and services manager confirmed that the results of the satisfaction survey in 2013 have not been shared with the council and the home has not sought the advice of the council in acting on the results. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

Observation performed on October 1, 2014, revealed that the soiled linen room #157 on main floor resident home area has a push-button door lock but the door was not locked and the room was unsupervised by staff. Inside the room, there were two bags of soiled linen and a chemical dispenser for neutral bathroom cleaner, odor counteractant, detergent/disinfectant, neutral cleaner accessible to any resident who is able to enter the room.

Interview with a PCA confirmed that the door was not locked. The push-button lock should lock the door when closed but it did not function properly. The staff mentioned that he/she would inform maintenance staff to fix the lock. Observation performed on later days confirmed that the push-button lock was fixed and the door lock worked properly. [s. 91.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's SDM was notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Interview with resident #10 indicated and record review revealed that on September 15, 2014, resident #10's SDM called the home to informed staff (NM) that the resident was upset because an identified staff commented to the resident in different occasions while providing care about the previously done facial care.

Record review revealed and interview with the nurse manager indicated that the incident was investigated and resident #10 was told that the identified staff would not be assigned to provide care to the resident, and confirmed that the resident's SDM was not informed of the outcome of the incident investigation. [s. 97. (2)]

WN #15: 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 used exclusively for drugs and drug-related supplies.

Observation performed on October 10, 2014, at 11:45 a.m., of the narcotic box located in the medication cart on the unit Garden indicated a presence of a jewelry. Interview with the registered nursing staff confirmed that they keep the valuables in the narcotic box, because of safety.

The narcotic box was not used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

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

Observation performed on October 1, 2014, revealed that a treatment cart on main floor, outside the nurse station, was unsupervised and not locked. The sliding drawers of the cart contained residents' medication creams and medical supplies.

The inspector informed the nurse manger who confirmed that the treatment cart was unsupervised and not locked. The nurse manger locked the cart. [s. 129. (1) (a) (ii)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home, in which the date the drug was received in the home is recorded.

Review of the medication shipping record and interview with registered nursing staff indicated that when a medication is received on the unit by the registered nursing staff, the shipping report is not always dated and signed. For instance, the shipping record with a date of printing July 27, 2014, was signed but not dated when the medications were received. [s. 133.]

WN #17: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

Review of the education records and interview with education program leader indicated 50 per cent of direct care staff were not trained in skin care and wound prevention management in 2013.

Interview with the education program leader confirmed that not all direct care staff received training in skin care and wound prevention management in 2013. [s. 221. (1) 2.]

2. The licensee has failed to ensure that training related to continence care and bowel management has been provided to all staff who provide direct care to residents on an annual basis.

Review of the education record for 2013, indicated 50% of all staff who provide direct care to residents were not provided training in continence care and bowel management.

Interview with the education program leader confirmed that not all staff received training in continence care and bowel management in 2013. [s. 221. (1) 3.]

WN #18: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member coordinating the program has the education in infection prevention and control practices, including, infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

Interview with the designated IPAC lead indicated that he/she has started the role for co-ordinating the program in August 2014. At the moment of the inspection, the staff confirmed that he/she has not received the IPAC education or enrolled in education specific to infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

Interview with the administrator indicated there was a previous leader of the IPAC program, from February to August 2014. Until the moment of the inspection the home was not able to provide proof of IPAC education of the previous leader. Interview with DON confirmed that the present designated IPAC lead does not have the formal education as required to co-ordinate the program and the staff would enroll for the IPAC education in the fall of this year. [s. 229. (3)]

2. The licensee has failed to ensure that there is access to point-of-care hand hygiene agents.

Observation performed on October 8, 2014, at 11:32 a.m., indicated a PCA put gloves on before entering room #242 in order to provide resident care. After the care, the PCA was observed assisting the resident with walking out of the room and performing hand hygiene using the hand sanitizer located in the hallway.

Interview with the PCA confirmed that she provided personal care to the resident in room #242 such as assisting with putting on the pants, glasses, and combing the resident hair. The PCA confirmed that she discarded the gloves, washed her hands in the bathroom of room #242, and used the hand sanitizer in the hallway. There was no access to a hand hygiene agent at the point of care if direct care staff need to clean their hands during provision of care. [s. 229. (9)]

Issued on this 9 day of December 2014 (A1)

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

Slavica Vucko

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SLAVICA VUCKO (210) - (A1)

Inspection No. / No de l'inspection : 2014_157210_0017 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-10-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 01, 2014;(A1)

Licensee / Titulaire de permis : TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

LTC Home / Foyer de SLD : CAREFREE LODGE
306 FINCH AVENUE EAST, NORTH YORK, ON, M2N-4S5

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Alice Marak

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To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used, the resident s bed system is evaluated in accordance with evidence-based practices and , if there are none, in accordance with prevailing practices, to minimize risk to the resident, and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The plan shall be submitted via email to slavica.vucko@ontario.ca by December 05, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

An inspection has been conducted on March 14, 2014, and a compliance order has been issued for the same provision O. Reg. 79/10, s. 15 (1), with a compliance date for July 31, 2014.

Interview with the DOC and the administrator indicated that the home had conducted a bed rail audit, and all the bed system was evaluated on September 24, 2014 by staff. The home uses a mattress/bed/side rail audit tool to record the room and bed number, type of bed, side rail length, type of mattress, length, width, risk, and sticker in place.

According to Health Canada's best practice document for bed system evaluation, appropriate method and measuring tools should be used during the evaluation to determine all potential zones of entrapment and other potential risks for resident entrapment.

Record review and staff interview confirmed that resident #3 and #7 were assessed to use a quarter bed rail for bed mobility, repositioning or transfer. A review of the audit tool indicated that the record for the bed system evaluation on September 24, 2014, was incomplete, only the types of bed and mattress have been recorded.

Interview with the supervisor of building services indicated that he conducted the bed system evaluation on September 24, 2014. During the evaluation, the staff tested the bed remote for proper functioning; observed the mattress size for proper fitting and the head board and foot board for proper installation; checked the bed rail for proper functioning. The staff confirmed that he/she did not measure any dimension of the entrapment zones but he/she only observed the gaps between the bed rail and the mattress and the bed rail and bed frame.

The supervisor of building services was not able to demonstrate that the home evaluated all potential entrapment zones for the risk of entrapment according to Health Canada's best practice document for bed system evaluation.
(565)

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 :

Jan 05, 2015(A1)

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
Performance Improvement and Compliance 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

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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
Direction de l’amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 9 day of December 2014 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : SLAVICA VUCKO - (A1)

Service Area Office /
Bureau régional de services : Toronto