Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 3, 2018	2018_737640_0013	011119-17, 027521-17, 027735-17, 002469-18, 002585-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 7, 8, 9, 10, 11, 14, 15, 16, 22, and 23, 2018.

This inspection was conducted concurrently with two complaint inspections, Inspection # 2018_737640_011 and #2018_737640_2018.

During the inspection, the following Critical Incident Reports were inspected:
Log #01119-17 related to an injury of a resident with transfer to hospital
Log #027521-17 related to a fall with significant change in condition
Log #027735-17 related to a fall with significant change in condition
Log #002469-18 related to a fracture of unknown origin
Log #002585-18 related to a fall with fracture
Log #005847-18 related to resident to resident altercation resulting in fracture
Log #001583-18 related to a fall with fracture
Log #027750-17 related to fall with significant change in condition

One complaint inquiry inspection was completed:
Log #026201-17 related to resident care and housekeeping

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapy (PT), Clinical Resource Nurse, Resident Assessment Instrument (RAI) Coordinator, Wound Care Nurse, Fall Prevention Lead, Behaviour Support Ontario (BSO) Lead, Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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 failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided care to the resident.

On a specified date in February 2018 resident #003 had altered skin integrity that required treatment. As a result they required increased level of care.

a) The home's Physiotherapist (PT) assessed the resident to require a higher level of care for lifts and transfers.

The home's policy "Safe Lifting with Care", policy #RC-08-01-11 with a revised date of April 2017, directed staff to include the resident's needs related to safe lifting and transfer on the resident's plan of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's plan of care and noted the plan of care related to the higher level of care had not been included until approximately three weeks after the PT assessment.

On a specified date in April 2018, the required higher level of care had been removed from the plan of care however the goal related to that care remained as a current goal on the plan of care.

During an interview with PSW #105, they informed the LTCH Inspector they had implemented the higher level of care but was unsure when it was implemented.

b) The plan of care was reviewed by the LTCH Inspector related to the altered skin integrity and the related treatment. There was a focus of altered skin integrity implemented on a specific date in February 2018. The interventions included a description of the site, to monitor for signs of infection and apply treatment as per the treatment plan.

The LTCH Inspector interviewed RPN #102 and #101 who informed the LTCH Inspector the home did not use a treatment record. All treatments and interventions were included on the electronic Medication Administration Record (MAR).

The LTCH Inspector reviewed the MAR for the month of February 2018, and there were no interventions included related to the care and treatment of the altered skin integrity.

c) During observation of resident #003, the LTCH Inspector observed several times over a two day period, sitting in a specific position.

During an interview with PSW #103, they informed the LTCH Inspector that they were to position in such a way to prevent falling forward. PSW #105 told the LTCH Inspector staff only implemented the intervention when needing to reposition the resident.

The LTCH Inspector reviewed the plan of care and was not able to locate any guidance or direction related to the use of the equipment for positioning or any other purpose.

During an interview with the Director of Care (DOC), they explained that the plan of care was expected to include all of the above items and to give clear direction to staff providing care and acknowledged the plan of care for resident #003 did not give clear direction to staff regarding the the use of the equipment. [s. 6. (1) (c)]

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

On a specified date in May 2017, resident #006 sustained a significant altered skin integrity. They required a higher level of care and treatment.

Over a two month period in 2017, the resident had several wound and skin assessments of the altered skin integrity which were not consistent in describing the location and type of altered skin integrity.

The home's policy "Skin and Wound Management", policy #RC 23-01-01 with a revised date of February 2017, directed staff to review skin and wound assessments to ensure the plan of care was integrated and consistent.

During an interview with RPN #107, the home's Skin and Wound Champion, they confirmed that all of the above assessments were completed on the same area of altered skin integrity. They stated it was an expectation of the home that the specific location of the altered skin integrity being assessed be documented on the assessment tool or note and that it be consistent throughout all assessments completed by any staff member until healed.

RPN #107 acknowledged the assessments listed above were not consistent, integrated or complete. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, b) the resident's care needs changed or care set out in the plan was no longer necessary.

a) On a specified date in November 2018, resident #004 fell and sustained a significant injury that required a higher level of care.

On a specified date in December 2018, the resident had a second fall and sustained significant injury that required a higher level of care.

Following the second fall, the resident required mobility equipment and increased assistance with their ADLs.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed that post-fall, staff were to update the interdisciplinary care plan in collaboration with the resident and family/SDM and obtain consent to the changes.

The plan of care following both falls remained unchanged. The implementation of the equipment for mobility had not been added to the plan of care. It remained they were independent with the use of different equipment.

During an interview with the Director of Care (DOC), they acknowledged that staff were to update the plan of care when the resident's condition changed and that had not occurred for resident #004 following either fall.

b) On a specified date in November 2018, resident #005 fell twice during the day. They had significant injury and required a higher level of care.

Prior to the falls, the resident was up with assistance of one staff. Following the fall, resident #005 required more assistance from staff as a result and became bed bound.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed that post-fall, staff were to update the interdisciplinary care plan in collaboration with the resident and family/SDM and obtain consent to the changes.

The plan of care following both falls remained unchanged. The implementation of the new interventions had not been added to the plan of care.

During an interview with the Director of Care (DOC), they confirmed that staff were to update the plan of care when the resident's condition and care requirements changed and that had not occurred for resident #005 following either falls.

The DOC acknowledged that staff did not update the plan of care to reflect the changes in resident #005's condition, level of assistance and risk for falls. [s. 6. (10) (b)]

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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each annual evaluation under clause (b) that included the date of the evaluation, the names of the

persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During a critical incident inspection related to responsive behaviours, the Long-Term Care Homes (LTCH) Inspector found the home to be non-compliant with s. 53 (4).

The LTCH Inspector was provided with a written record titled “Responsive Behaviour Program Evaluation” from the Director of Care (DOC).

The LTCH Inspector reviewed the written record and found the record did not include a date the evaluation was held, a summary of changes made and the date those changes were implemented.

During an interview with the DOC, they acknowledged the written record was deficient as above. [s. 53. (3) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified where possible; (b) strategies were developed and implemented to respond to the behaviours where possible; and (c) actions were taken to respond to the needs of the resident, to include assessments, reassessments and interventions and that the resident’s responses to the interventions were documented.

1) Resident #009 was admitted to the home in November 2017 and could not speak or understand English. They had a history of specific medical conditions.

On a specified date in March 2018 resident #009 had an altercation with another resident who caused injury to resident #009 and as a result resident #009 required a higher level of care.

The LTCH Inspector interviewed RPN #115, the Behavioural Support Ontario (BSO) Lead who stated the resident gets upset as staff don't understand their language.

They had documented in the progress notes when they had observed the resident having responsive behaviours. The staff member who could understand the resident, had identified that on one occasion the resident had complained of an illness, the inability at times to find their way and that they did not like certain staff members.

During an interview with PSW #116, the primary PSW for the resident at the time of the incident, stated there was a language barrier. The resident did not understand english. We had some communication cards but they didn't help much.

The PSW stated that the best intervention was one on one with someone who could understand the language. Sometimes staff would ask a staff member who spoke the same language to find out what the resident wanted.

The home's policy "Mental Health and Responsive Behaviours", policy #RC-17-01-01 with a revised date of February 2017, directed staff to ensure the care plan contained at a minimum:

a) Triggers to behaviour
b) Goals based on MDS scores - DRS, CAM and CPS
c) Ways to complete a task or ADL that minimized the likelihood of a behaviour appearing
d) What the behaviour actually was
e) Interventions to deal with the behaviour
f) What to do if the intervention is not effective or behaviour escalates; and
g) Fluctuations in the resident behaviour including times when the behaviour more prevalent.

The LTCH Inspector reviewed the clinical record of resident #009 with RPN #115, the home's BSO Lead, and found the plan of care did not include any responsive behaviour triggers, strategies or interventions to deal with each responsive behaviour and the interventions and the resident's responses to interventions were not documented.

During an interview with the Director of Care, they acknowledged the resident's plan of care did not include responsive behaviours, triggers, strategies and interventions for resident #009.

2) Resident #010 had multiple medical conditions, responsive behaviours and had a Cognitive Performance Scale (CPS) score of 3.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector which included the written plan of care that identified only one specific responsive behaviour. The goal was to have a reduction in episodes and the interventions were not specifically related to reducing the specific responsive behaviours.

The resident had a prior history of a specific responsive behaviour which was not included as a focus or goal. The interventions related to the specific responsive behaviour did not address the specific responsive behaviour.

The LTCH Inspector interviewed PSW #116 who told the LTCH Inspector the resident did frequently have the specific responsive behaviour, they did not know what triggered this behaviour.

During an interview with RPN #118, they informed the LTCH Inspector they were not aware of what the trigger(s) were for the specific responsive behaviour.

The clinical record contained two specific assessments that were completed but had not had a full date to include the year they were done. There were also three other types of specific assessments completed in December 2017 that identified several behaviours.

The plan of care did not identify or address any of the issues above except for one specific responsive behaviour.

During an interview with RPN #118 they acknowledged the plan of care did not identify triggers, effective strategies and interventions to address the identified responsive behaviours for resident #010.

3) Resident #012 was admitted with multiple medical diagnoses.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector which included the written plan of care that identified three responsive behaviours.

The LTCH Inspector interviewed PSW #116 who told the LTCH Inspector the resident was physically aggressive at times. They did not know what triggered this behaviour. The PSW stated the interventions they used were sometimes effective but when disruptive, the resident was taken back to their bedroom.

During an interview with RPN #118, they informed the LTCH Inspector of the same responsive behaviours and interventions. The RPN was not aware of what the trigger(s) were for any of the noted responsive behaviours.

The RPN and the LTCH Inspector reviewed the clinical record regarding assessments or behaviour monitoring and both the RPN and the PSW could not recall any responsive behaviour assessments being completed by staff or others.

During an interview with RPN #118 they acknowledged the plan of care did not identify triggers for this resident and effective strategies and interventions to address the identified responsive behaviours. [s. 53. (4) (a)]

Additional Required Actions:

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

WN #3: 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. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including Falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

On a specified date in November 2018, resident #004 fell and and had a significant injury that required a higher level of care.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed staff to assess the following every shift for 72 hours post-fall:

a) Pain;
b) Bruising;
c) Change in functional status;
d) Change in cognitive status; and
e) Changes in range of motion.

Document the fall and results of all assessments and actions taken during the 72 hour post-fall follow-up and update the interdisciplinary care plan in collaboration with the resident and family/SDM.

The Long-Term Care Homes (LTCH) Inspector interviewed the Falls Lead for the home, RN #100 who informed the LTCH Inspector that staff were to complete a post-fall clinical monitoring assessment every shift for 72 hours following a fall.

The LTCH Inspector reviewed the clinical record of resident #004. Post-fall assessments had not been conducted on five identified shifts.

During an interview with the Director of Care (DOC), they acknowledged staff were to complete a post-fall assessment every shift for 72 hours following a fall and staff had not followed the home’s policy. [s. 8. (1) (a),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 the licensee is required to ensure that any plan, policy, protocol, procedure, strategy or system that is required to be in place is (b) complied with, to be implemented voluntarily.

WN #4: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. 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 failed to ensure that the plan of care was based on 10. Health conditions, including allergies, pain, risk of falls and other special needs.

Resident #005 was assessed in May 2017 as low risk for fall. The clinical record did not include any other fall risk assessments. The assessment stated to implement universal fall prevention precautions.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed staff to create an individualized plan of care addressing identified fall causes and risk factors and to follow all regulatory and local authority written directives related to falls.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's plan of care and

identified there were no references related to the risk of falls in the plan of care.

During an interview with the Director of Care (DOC), they acknowledged that staff were to follow all regulatory written directives and include the risk of falls in the plan of care. [s. 26. (3) 10.]

2. The licensee failed to ensure that the plan of care, was based on, at a minimum, interdisciplinary assessment of a resident's skin condition, including altered skin integrity and foot conditions.

Resident #006 sustained a significant alteration to skin integrity that required a higher level of care.

The home's policy "Skin and Wound Management", policy #RC 23-01-01 with a revised date of February 2017, directed staff to update the plan of care to reflect the altered skin integrity focus, including the current goals and interventions.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #006 and was not able to identify any revisions to the written plan of care related to the altered skin integrity as above.

The LTCH Inspector reviewed the resident's Medication Administration Record (MAR), where the home documented scheduled treatments, and the MAR included a specific treatment to be applied to altered skin integrity, but did not specify which location or the type of altered skin integrity.

The home's Skin and Wound Champion, RPN #107 informed the LTCH Inspector it was an expectation of the home that new areas of altered skin integrity, their location, type, size and treatments would be included in the resident's plan of care. [s. 26. (3) 15.]

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 the licensee must ensure that the plan of care is based on, at a minimum, 10. Health conditions, including allergies, pain, risk of falls and other special needs and 15. interdisciplinary assessment of a resident's skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During a Critical Incident Inspection regarding resident #003, #004, #005 and #010, the home was found to have non-compliance related to falls prevention and management.

The Long-Term Care Homes (LTCH) Inspector requested the annual evaluation of the falls prevention and management program from the Director of Care (DOC). The DOC informed the LTCH Inspector the home had not completed an annual evaluation of the program since January 2017 for the calendar year of 2016.

During an interview with the DOC, they acknowledged the program evaluation did not meet the legislative requirements as above. [s. 30. (1) 3.]

2. The licensee failed to ensure that a written record related to the evaluation of the skin and wound care program included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During a Critical Incident Inspection regarding resident #003, #004 and #006, the home was found to have non-compliance related to skin and wound care management.

The Long-Term Care Homes (LTCH) Inspector requested the annual evaluation of the skin and wound care program from the Director of Care (DOC).

The annual skin and wound care program review record was reviewed by the LTCH Inspector which revealed the following;

a) There was no date the evaluation of the program was completed,
b) there were no "summary of changes" made to the program, and
c) no dates the changes were implemented.

During an interview with the DOC, they acknowledged the program evaluation did not meet the legislative requirements as above. [s. 30. (1) 4.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specified date in February 2018, resident #003 required a higher level of care related to a post fall injury and subsequent significant altered skin integrity on a specific area on their body.

A head-to-toe skin assessment had been conducted on a different area of altered skin integrity with no mention of the more significant area of altered skin integrity.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record which revealed no skin assessment to have been completed related to the area of significant altered skin integrity.

The home’s policy "Skin and Wound Management", policy #RC-23-02-02 with a revised date of February 2017, defined altered skin integrity as the potential or actual disruption of epidermal or dermal tissue to include all skin breakdown, including but not limited to bruises, skin tears, rashes, wounds/ulcers, burns and lesions.

The policy directed that any resident exhibiting any form of altered skin integrity as above, would receive a skin assessment by a Nurse using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The assessment tool in place for a wound was "Impaired Skin Integrity Assessment."

During an interview with RN #100, a Clinical Practice Lead for the home, they informed the LTCH Inspector it was an expectation of the home that staff complete a skin assessment using the “Impaired Skin Integrity Assessment” form for the area of significant altered skin integrity.

RN #100 acknowledged there were no assessments of the significant altered skin integrity completed by the home. [s. 50. (2) (b) (i)]

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 The licensee must ensure that a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A) On specified date in January 2018, resident #010 fell. At 1000 hours the same date, staff noted an injury that required a higher level of care.

The following day the home was notified of the resident's specific injury and treatment was initiated.

Three days following the incident and two days following the receipt of specific information, the home notified the Director of the incident.

During an interview of RN #100, the staff who informed the Director by way of a Critical Incident Response form, they told the LTCH Inspector they had not known about the injury until two days after the incident. The clinical record was reviewed by the RN and the LTCH Inspector to note the home was aware one day following the incident that the resident had sustained a significant injury.

B) On a specified date in January 2018 resident #007 had an assessment which identified the need for a higher level of care.

On the same date, the home was notified that resident #007 had a significant injury that required specific treatment.

Three days after the incident and after the home was aware of the significant injury, the home notified the Director of the incident.

During an interview with the Director of Care (DOC), they acknowledged the home was late in informing the Director of the incident.

C) On a specific date in November 2017, resident #004 fell which resulted in a significant injury that required a higher level of care.

On a specific date in December 2017, resident #004 sustained a second fall with significant trauma and required a higher level of care for several days.

During an interview with the Director of Care (DOC), they stated they had not submitted a Critical Incident Response (CI) form for the second fall with injury and the requirement of a higher level of care.

During an interview with the DOC, they acknowledged the home did not notify the Director regarding the fall with significant injury and requirement of a higher level of care. [s. 107. (3)]

2. The licensee failed to ensure that when required to make a report in writing to the Director, the report was to include the date and time of the incident.

a) On a specified date in January 2018 resident #010 fell, sustained an significant injury that required a higher level of care.

The date of the incident on the Critical Incident Response form was noted to be two days after the initial incident.

During an interview with RN #100, they acknowledged the date of the incident was incorrectly documented to the Director.

b) On a specified date in January 2018, resident #007 was found with altered skin integrity.

The resident was assessed and required a higher level of care.

The date of the incident on the Critical Incident Response form stated the incident occurred three days later than the actual occurrence date.

During an interview with the Director of Care, they acknowledged the date of the incident was incorrectly documented to the Director. [s. 107. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #8: 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:
1. Falls prevention and management. 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for the purposes of paragraph 6 of subsection 76(7)

of the Act, that training was provided to all staff who provided direct care to residents related to falls prevention and management, skin and wound care and responsive behaviours.

1) During a Critical Incident Inspection regarding resident #003, the home was found to have non-compliance related to falls prevention and management.

The Long-Term Care Homes (LTCH) Inspector requested the percentage of all staff that provided direct care that received education and/or training related to falls prevention and management.

The "Course Completions" document as provided by the Director of Care (DOC) to the LTCH Inspector for the calendar year 2017, indicated that 97% of nursing staff were provided training for falls prevention and management.

During an interview with the DOC, they acknowledged that not all staff participated in the education related to falls prevention and management.

2) During a Critical Incident Inspection regarding resident #003 and #006, the home was found to have non-compliance related to skin and wound care management.

The Long-Term Care Homes (LTCH) Inspector requested the percentage of staff that received education and/or training related to the skin and wound care program.

The "Course Completions" document as provided by the Director of Care (DOC) to the LTCH Inspector for the calendar year 2017, indicated that 93% of nursing staff were provided training for skin and wound management.

During an interview with the DOC, they acknowledged that not all staff participated in the education related to skin and wound care management.

The licensee failed to ensure that all staff participated in skin and wound care training/education.

3) During a critical incident inspection related to responsive behaviours, the Long-Term Care Homes (LTCH) Inspector found the home to be non-compliant with s. 53 (4).

The Director of Care (DOC) provided a copy of an email dated May 15, 2018, stating that

responsive behaviour training/education was "not on the 2017 training".

The DOC acknowledged the required training related to responsive behaviour management did not occur in 2017. [s. 221. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that, for the purposes of paragraph 6 of subsection 76(7) of the Act, that training is provided to all staff who provide direct care to residents related to falls prevention and management, skin and wound care and responsive behaviours, to be implemented voluntarily.

Issued on this 14th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2018_737640_0013
Log No. / No de registre :	011119-17, 027521-17, 027735-17, 002469-18, 002585-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 3, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Brampton 7891 McLaughlin Road, BRAMPTON, ON, L6Y-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hannah Oksemberg

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) (b) of the LTCHA.

Specifically the licensee must:

a) Ensure that the plan of care for resident #004 and #005 are reviewed and revised related to the implementation of appropriate fall prevention strategies.

b) Ensure that resident #004 and #005 and any other residents are reassessed and the plan of care is reviewed and revised when the resident's care needs change following a fall.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, b) the resident's care needs changed or care set out in the plan was no longer necessary.

a) On a specified date in November 2018, resident #004 fell and sustained a significant injury that required a higher level of care.

On a specified date in December 2018, the resident had a second fall and sustained significant injury that required a higher level of care.

Following the second fall, the resident required mobility equipment and increased assistance with their ADLs.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed that post-fall, staff were to update the interdisciplinary care plan in collaboration with the resident and family/SDM and obtain consent to the changes.

The plan of care following both falls remained unchanged. The implementation of the equipment for mobility had not been added to the plan of care. It remained they were independent with the use of different equipment.

During an interview with the Director of Care (DOC), they acknowledged that staff were to update the plan of care when the resident's condition changed and that had not occurred for resident #004 following either fall.

b) On a specified date in November 2018, resident #005 fell twice during the day. They had significant injury and required a higher level of care.

Prior to the falls, the resident was up with assistance of one staff. Following the fall, resident #005 required more assistance from staff as a result and became bed bound.

The home's policy "Falls Prevention and Management Program", policy #RC-15-01-01 with a revised date of February 2017, directed that post-fall, staff were to update the interdisciplinary care plan in collaboration with the resident and family/SDM and obtain consent to the changes.

The plan of care following both falls remained unchanged. The implementation of the new interventions had not been added to the plan of care.

During an interview with the Director of Care (DOC), they confirmed that staff were to update the plan of care when the resident's condition and care requirements changed and that had not occurred for resident #005 following either falls.

The DOC acknowledged that staff did not update the plan of care to reflect the changes in resident #005's condition, level of assistance and risk for falls. [s. 6.

(10) (b)]

The severity of this issue was determined to be minimal harm or potential for actual harm (2). The scope of the issue was determined to be a pattern (2). The home had a compliance history of ongoing non-compliance despite previous action taken by the ministry (4) that included:

- RQI Inspection #2015_301561_0018 issued a voluntary plan of correction (VPC)
- RQI Inspection #2017_561583_0021 issued a VPC related to Falls Prevention

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with r. 53 (4) of the LTCHA.

Specifically the licensee must:
a) Ensure that resident #009, #010, #012 and any other residents are reassessed to identify triggers for their responsive behaviours, where possible.

b) Ensure that resident #009, #010, #012 and any other residents have strategies and interventions developed and implemented to respond to their responsive behaviours.

c) Ensure that resident #009, #010, #012 and any other residents responses to interventions are documented.

d) Ensure that resident #009, #010, #012 and any other residents have their plan of care reviewed and revised to reflect the triggers, strategies and interventions.

Grounds / Motifs :

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

During a critical incident inspection related to responsive behaviours, the Long-Term Care Homes (LTCH) Inspector found the home to be non-compliant with s. 53 (4).

The LTCH Inspector was provided with a written record titled "Responsive Behaviour Program Evaluation" from the Director of Care (DOC).

The LTCH Inspector reviewed the written record and found the record did not include a date the evaluation was held, a summary of changes made and the date those changes were implemented.

During an interview with the DOC, they acknowledged the written record was deficient as above. [s. 53. (3) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified where possible; (b) strategies were developed and implemented to respond to the behaviours where possible; and (c) actions were taken to respond to the needs of the resident, to include assessments, reassessments and interventions and that the resident's responses to the interventions were documented.

1) Resident #009 was admitted to the home in November 2017 and could not speak or understand English. They had a history of specific medical conditions.

On a specified date in March 2018 resident #009 had an altercation with another resident who caused injury to resident #009 and as a result resident #009 required a higher level of care.

The LTCH Inspector interviewed RPN #115, the Behavioural Support Ontario (BSO) Lead who stated the resident gets upset as staff don't understand their language.

They had documented in the progress notes when they had observed the resident having responsive behaviours. The staff member who could understand the resident, had identified that on one occasion the resident had complained of an illness, the inability at times to find their way and that they did not like certain staff members.

During an interview with PSW #116, the primary PSW for the resident at the time of the incident, stated there was a language barrier. The resident did not understand english. We had some communication cards but they didn't help much.

The PSW stated that the best intervention was one on one with someone who could understand the language. Sometimes staff would ask a staff member who spoke the same language to find out what the resident wanted.

The home's policy "Mental Health and Responsive Behaviours", policy #RC-17-01-01 with a revised date of February 2017, directed staff to ensure the care plan contained at a minimum:

a) Triggers to behaviour
b) Goals based on MDS scores - DRS, CAM and CPS
c) Ways to complete a task or ADL that minimized the likelihood of a behaviour appearing
d) What the behaviour actually was
e) Interventions to deal with the behaviour
f) What to do if the intervention is not effective or behaviour escalates; and
g) Fluctuations in the resident behaviour including times when the behaviour more prevalent.

The LTCH Inspector reviewed the clinical record of resident #009 with RPN #115, the home's BSO Lead, and found the plan of care did not include any responsive behaviour triggers, strategies or interventions to deal with each responsive behaviour and the interventions and the resident's responses to interventions were not documented.

During an interview with the Director of Care, they acknowledged the resident's plan of care did not include responsive behaviours, triggers, strategies and interventions for resident #009.

2) Resident #010 had multiple medical conditions, responsive behaviours and had a Cognitive Performance Scale (CPS) score of 3.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector which included the written plan of care that identified only one specific responsive behaviour. The goal was to have a reduction in episodes and the

interventions were not specifically related to reducing the specific responsive behaviours.

The resident had a prior history of a specific responsive behaviour which was not included as a focus or goal. The interventions related to the specific responsive behaviour did not address the specific responsive behaviour.

The LTCH Inspector interviewed PSW #116 who told the LTCH Inspector the resident did frequently have the specific responsive behaviour, they did not know what triggered this behaviour.

During an interview with RPN #118, they informed the LTCH Inspector they were not aware of what the trigger(s) were for the specific responsive behaviour.

The clinical record contained two specific assessments that were completed but had not had a full date to include the year they were done. There were also three other types of specific assessments completed in December 2017 that identified several behaviours.

The plan of care did not identify or address any of the issues above except for one specific responsive behaviour.

During an interview with RPN #118 they acknowledged the plan of care did not identify triggers, effective strategies and interventions to address the identified responsive behaviours for resident #010.

3) Resident #012 was admitted with multiple medical diagnoses.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector which included the written plan of care that identified three responsive behaviours.

The LTCH Inspector interviewed PSW #116 who told the LTCH Inspector the resident was physically aggressive at times. They did not know what triggered this behaviour. The PSW stated the interventions they used were sometimes effective but when disruptive, the resident was taken back to their bedroom.

During an interview with RPN #118, they informed the LTCH Inspector of the same responsive behaviours and interventions. The RPN was not aware of what the trigger(s) were for any of the noted responsive behaviours.

The RPN and the LTCH Inspector reviewed the clinical record regarding assessments or behaviour monitoring and both the RPN and the PSW could not recall any responsive behaviour assessments being completed by staff or others.

During an interview with RPN #118 they acknowledged the plan of care did not identify triggers for this resident and effective strategies and interventions to address the identified responsive behaviours. [s. 53. (4) (a)]

The severity of the issue was determined to be minimal harm or potential for harm (2). The scope was widespread (3) as it related to three of three reviewed. The home had a compliance history of one or more unrelated non-compliance in the last three full years. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

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

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

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

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Heather Preston

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