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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2015	2014_250511_0029	H-001642-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HAMILTON
90 CHEDMAC DRIVE HAMILTON ON L9C 7S6

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

ROBIN MACKIE (511), BARBARA NAYKALYK-HUNT (146), KELLY HAYES (583), MICHELLE WARRENER (107), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 8, 9, 10, 11, 12, 15, 16, 17, 2014.

The following Critical Incident Reports were inspected with this RQI: H-00318-14, H-000894-14,H-000894-14. The following Complaints were inspected with this RQI: H-001519 -14, H-001259-14.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Acting Associate Director of Care (ADOC), Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator, Clinical Coordinator, Environmental Service Manager (ESM), Recreation Manager, Food Service Supervisor, registered staff consisting of: Registered Nurse (RN), Registered Practical Nurse (RPN), Physiotherapist (PT) and Registered Dietitian (RD), Personal Support Workers (PSW's), dietary staff, housekeeping staff, recreation staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
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
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

19 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

A) Resident #023's care plan indicated that the resident was able to toilet them self under the toileting focus of the care plan; however, under the urinary function focus, the plan indicated that one staff was required to toilet the resident; and then, under the transfer focus, the plan indicated that two staff were required to provide assistance to transfer the resident from the bed to wheelchair. The directions to staff were not clear.

B) Resident #001's plan of care, under the focus of toileting, directed staff to use two staff and a mechanical lift to transfer the resident; however, under the focus of transferring, staff were directed to use one staff to transfer. Staff confirmed that they were using a one person transfer and no mechanical lift. The directions in the plan of care were unclear as confirmed by the acting DOC. [s. 6. (1) (c)]

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

A) Resident #301's plan of care required pudding consistency and thickened fluids with meals. The resident was provided honey consistency, thickened fluids (as confirmed by staff assisting the resident with eating) at the lunch meal in December 2014. The resident had a wet cough after consuming their thickened fluids and was coughing repeatedly throughout the meal. Staff stated that they did not observe the resident with the same cough at the breakfast meal that day. The resident was not provided the correct consistency of thickened fluids as outlined in their plan of care.(107)

B) A review of the plan of care for resident #600 identified they were at a high nutritional risk and required a high calorie, high protein specific meal. On a day in December 2014, during a meal observation, resident #600 was not provided their high calorie, high protein meal. It was confirmed with the Dietary Aid (DA) that the intervention was documented on the diet list sheets, which the DA referenced during meal service, and that the high calorie, high protein meal was not provided as specified in the plan. In an interview with the Registered Dietitian (RD) in December 2014, it was confirmed that resident #600 was assessed at high nutrition risk and required a high calorie, high protein meal to meet their nutrition requirements.

C) A review of the plan of care indicated resident #005 was at high nutrition risk due to significant weight loss, poor intake and altered skin integrity, and was to be provided a specified supplement with each meal for added calories and protein. During lunch service on a day in December 2014, resident #005 was provided only half of the specified supplement by the registered nursing staff. In an interview with the registered nursing staff they confirmed resident #005 was to receive the full amount of the specified supplement, as directed by the medication administration record, and that the nutritional supplement was not provided as specified in the plan.

D) During lunch service on a day in December 2014, resident #005 was not brought to the dining room, was observed to be awake in bed and when asked by inspector #583 if

they were hungry, they responded "yes". In an interview with the registered staff and non registered staff it was stated that resident #005 eats a meal in bed because they have altered skin integrity. A review of the plan of care identified that resident #005 was to be transferred into bed after their meal, daily to provide pressure relief. In an interview with the registered nursing staff on a day in December 2014 it was confirmed the care provided was not as specified in the plan. (583)

E) A review of the clinical record indicated resident #043 had been referred and seen by the RD for swallowing difficulty on a specific day in 2014. The RD recommended nectar thickened fluids and indicated the order was written, the plan of care updated, and the RD would continue to monitor the resident's response. The resident's plan of care was updated by the RD on the same day in 2014 and indicated nectar thickened fluids. After the specific date that the RD had updated the care plan in 2014 the progress notes indicated that the resident was noted to have a cough when they consumed thin fluids and a request for the doctor to assess was indicated in the doctor's book. Approximately one month later a cup that was half full of water, that had not been thickened, was observed at the resident's bedside. Interview with two PSW's confirmed the resident had continued to receive water that had not been thickened. Interview with the RD confirmed the care set out in the plan of care for resident #043 was not provided to the resident as specified in the plan. (511)

F) A review of resident #005's plan of care indicated the resident had altered skin integrity that required a treatment and dressing change every two days during the month of December 2014. A review of the December 2014 electronic Treatment Authorization Record (eTAR) indicated the dressing was changed every three days. Interview with the registered staff confirmed the dressing was not changed as set out in the plan of care. (511)

3. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #043's clinical record review confirmed the resident required nectar think fluids on a day in November, 2014 as directed by the RD. The plan of care that was available to the front line staff was located in a binder at the nursing station, was dated earlier in November, 2014 and indicated the resident still required regular texture/regular fluid. The PSW's confirmed the resident received regular fluid. Interview with the RD confirmed they updated the plan of care electronically, to nectar thick fluids but was unable to print

the updated plan of care that was made available to the direct care staff at the nursing station. Interview with the MDS-RAI Coordinator confirmed that the licensee did not ensure the PSW's, who provided direct care to resident #043, had convenient and immediate access to the most recent plan of care. [s. 6. (8)]

4. The licensee has 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 the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of resident #042's clinical record confirmed they experienced a respiratory infection, which required treatment, in an identified month in 2014. Documentation indicated the resident recovered from the respiratory infection the following month in 2014. The plan of care, dated four months later, indicated the resident still had a respiratory infection which required an antibiotic and notification to the MD if symptoms had not resolved. Interview with the MDS-RAI Coordinator confirmed the resident did not have another respiratory infection as indicated in the plan of care and that the plan of care was not revised when the resident's care needs, set out in the plan, were no longer necessary. (511)

B) Resident #001's current plan of care directed staff to check for the resident's hearing aid because the resident may wrap them in tissue and they might be discarded. Interview with the staff confirmed that the resident had not had their hearing aids since August 2014 and that the care plan had not been revised when the resident's care needs changed. (146)

C) Resident #001's current plan of care directed staff to wear personal protective equipment (PPE) when providing care due to the presence of a resistant organism. Two, out of two registered staff interviewed stated that the resident did not have a resistant organism and agreed that the direction was added when the resident had a return from a hospital admission in 2014. The registered staff confirmed that the care plan had not been revised when the resident's care needs changed.(146)

D) A review of the plan of care for resident #005 identified they required limited assistance with eating and used a lip plate for entrees. During a meal observation in December 2014, resident #005 required total assistance from staff with feeding and had not received a lip plate. In an interview, with the registered and non registered nursing staff in December 2014, it was stated that resident #005's condition had changed and they no longer required a lip plate as they required total assistance for feeding by staff.

In a progress note, completed by the Registered Dietitian (RD) in November 2014, it was confirmed that resident #005 required total feeding assistance. In an interview with the RD in December 2014 it was verified that the plan of care was not revised when the resident's feeding assistance needs changed.(583)

E) A review of Resident #005's plan of care indicated the resident required two separate topical creams to be applied; one, three times a day and the other, four times a day. Interview with the registered staff confirmed the medication had been previously discontinued and the resident's plan of care was not revised, in order to remove the intervention of applying the cream, when the care set out in the plan was no longer necessary.(511) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident will be reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 the resident had been assessed in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #035 was observed during Stage one of the RQI, to be in bed with two, three quarter bed rails in the raised position. A review of the clinical record did not indicate the resident was assessed for safety in relation to the potential risk of entrapment from the use of the two, three quarter bed rails when the resident was in bed. Interview with the Acting Administrator confirmed the home had not assessed residents in their bed, specifically resident #035, to minimize risk when the use of bed rails were indicated. (511)

B) Resident #001 used raised full bed rails when in bed at the family's request. The Acting Director of Care and Environmental Service Manager (ESM) confirmed that the resident was not assessed, to minimize risk to the resident when the use of bed rails were indicated.(146) [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) During stage one of the RQI, bed rails were observed to be used, specifically for resident #035, who required the use of two, three quarter rails. A review of a facility document titled, "Facility Entrapment Inspection Sheet", indicated 159 beds were assessed on May 12, 2014 for zones of entrapment. Of the 159 beds assessed, 118 beds were documented to have failed the inspection, indicating multiple zones of entrapment. Interview with the Acting Administrator confirmed the home used bed rails and had knowledge of the risk on zones of entrapment since the May 12, 2014 inspection document. The Acting Administrator was unable to confirm how many of the 118 beds had interventions completed to address the identified risks, taking into consideration all potential zones of entrapment, and whether the 118 beds still posed a potential risk for zones of entrapment.(511)

B) Resident #001's bed system was assessed by a third party on May 12, 2014. The bed failed in zones 2, 3 and 4 on May 12, 2014. The DOC and ESM confirmed that steps were not taken to prevent resident entrapment.(146) [s. 15. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #701 was protected from abuse by resident #700.

Resident #700 had a diagnosis of dementia and exhibited responsive behaviours, which included aggression towards co-residents.
In 2014, resident #700 grabbed resident #701, demonstrated physical aggression towards resident #701 which resulted in an injury from the altercation. Resident #701 was transferred to the hospital where they received treatment
It was confirmed by the Acting Director of Care that resident #701 was not protected from abuse by resident #700. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #701 is protected from abuse by resident #700, to be implemented voluntarily.

WN #4: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a Registered Dietitian who was a member of the staff of the home.

A) A review or resident #041's clinical record identified a Wound Care record , dated February 2014, that indicated the resident had developed an alteration in their skin integrity. The Registered Dietitian (RD) had assessed the resident in December 2013 at a quarterly review and noted the resident had no alteration in skin integrity at that time. The next RD assessment was completed, as a quarterly assessment in March 2014, nearly one month after the home had knowledge of the resident's altered skin integrity. The RD noted nutritional interventions were required to promote healing of the wound. Interview with the Registered Nurse, responsible for wound care within the home, confirmed the RD had not received a Nutrition-Referral from the nursing staff and an interview with the RD confirmed the RD had not assessed resident #041's wound when the home became aware of the alteration in skin integrity.(511)

B) A review of the plan of care for resident #001 identified they developed a new alterations in skin integrity in October 2014 as described on the the Weekly Wound Care Record. A review of the plan of care showed that a Nutrition-Referral to the Registered Dietitian (RD) was not completed and the RD had completed a quarterly nutrition assessment in November 2014. In an interview with the RD in December 2014 it was stated that they had not received a referral for resident #001's altered skin integrity in October 2014, and that the resident was not assessed to see if changes to the nutrition plan of care were required related to their new alteration in their skin integrity.(583)

C) A review of the plan of care for resident #005 identified they were at a high nutritional risk and developed an alteration in their skin integrity in November 2014 per the home's Weekly Wound Care Record. A review of the plan of care showed a Nutrition-Referral to the Registered Dietitian (RD) had not been completed. In an interview with the RD on December 16, 2014 it was stated that they had not received a referral for resident #005's new alteration in skin integrity. It was confirmed that resident #005 had not been assessed to see if changes to the nutrition plan of care were required related to their new alteration in skin integrity.(583) [s. 50. (2) (b) (iii)]

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 residents 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted:
Every resident had the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A) On December 15, 2014, during a medication administration observation, the nurse was observed to throw the emptied medication packets that had been labeled with the residents' names and medications into the regular garbage. The nurse confirmed that this was a widespread practice and that the packets were always disposed of in the regular garbage. The Acting Associate Director of Care confirmed that this practice does not protect the residents' personal health information. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was:
(a) in compliance with and was implemented in accordance with all applicable requirements under the Act.

Specifically, Regulation 50. (2) (b), stated a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers,skin wounds and tears,
(iii) would be assessed by a Registered Dietitian who was a member of the staff of the home.

The home's Acting Administrator provided the following policies for review:
1. Skin Care Program Overview, policy number 03-01, dated June 2010.
2. Pressure Ulcers, policy number 03-07, dated June 2010.
3. Wound Care Record, policy number 03-09, dated June 2010.
4. Preventative Skin Care, policy number 03-03, dated June 2010.
5. Skin Tears, policy number 03-06, dated June 2010.
6. Stasis Ulcers, Surgical and Other Wounds, policy number 03-08, June 2010.
7. Skin Treatments, policy number 11-08, September 2010.

The home's policy for pressure ulcers is the only policy that referenced the need to refer to the RD and was as described below:
Registered staff were to refer to the Dietitian at Stage One for dietary assessment if there was a reduced food or fluid intake or if the resident was at a moderate or high nutritional risk.
Interview with the Wound Care coordinator confirmed the RD was not referred to for all alterations to a resident's skin integrity and the RD assessment would often be completed at the next RD quarterly assessment. [s. 8. (1) (a)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted 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, (b) was complied with.

A) The medication management policy Clin 11-03 stated that the registered staff were not to pre-pour medications for residents; that the rule of check one, pour one and sign for one was to be followed at all times and that one resident's medication was to be administered before going on to the next resident.
According to the Critical Incident Report, a nurse pre-poured and crushed medications for two residents in 2014, put them in the cart drawer and then gave the wrong medications to resident #400. This information was confirmed by the Acting DOC. [s. 8. (1) (b)]

WN #7: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that plan of care must be based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: 3. Communication abilities, including hearing and language.

Resident #035's Minimum Data Set Resident Assessment Protocol (MDS RAP), completed in October 2014, indicated the resident experienced communication challenges that consisted of being able to hear in special situations only, difficulty in being understood and difficulty understanding others. The RAP identified resident #035's communication needs would be care planned. A review of the resident's most recent plan of care, dated October 2014 did not include the resident's communication abilities or interventions. Interview with the MDS-RAI Coordinator confirmed the resident's communication needs were not included in the resident's plan of care. [s. 26. (3) 3.]

2. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included their identified responsive behaviours and potential behavioural triggers.

Resident #700 had a diagnosis of dementia and exhibited responsive behaviours. The resident's plan of care, which provided staff with direction to provide care to residents,

indicated that resident #700 had only two specific responsive behaviours.

In April 2014, resident #700 was assessed by the Psychogeriatric Resource Consultant (PRC) and recommendations were provided to manage the resident's behaviours. A review of the recommendations indicated that the resident's responsive behaviours were being triggered on the unit and may have been related to the resident's past life experiences.
The report indicated that the triggers would cause the resident anxiety and may have provoked responsive behaviours. This trigger that had been identified by the Psychogeriatric Resource Consultant (PRC) was not identified on the resident care plan. The consultation and recommendation report indicated that the report was not part of the resident's clinical record.
In July 2014 resident #700 grabbed resident #701 and demonstrated physical aggression that resulted in an injury to resident #700 that required medical treatment.
Resident #700's plan of care did not identify that the resident had responsive behaviours to include aggression towards co-residents, including triggers to this behaviour.
Interviews conducted with PSW staff in December 2014, confirmed that resident #700 had demonstrated responsive behaviours towards co-residents that included physical aggression.
It was confirmed by the Acting Director of Care in December 2014, that the resident's plan of care did not include all of resident #700's responsive behaviours and all of the resident's behavioural triggers that had been identified. [s. 26. (3) 5.]

3. The licensee has failed to ensure that the plan of care was 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.

A) Resident #401 returned from a hospital visit in 2014 with a transfer note that indicated the resident had an Antibiotic Resistant Organism (ABO). The resident was observed during the same month in 2014 to have an isolation cart outside their room door with a precaution sign. However, the plan of care did not address this special need when reviewed during the same month in 2014. This information was confirmed by registered staff. [s. 26. (3) 18.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where there was a written policy to minimize the restraining of residents and that the policy was complied with.

The home's Physical Restraints policy, reference # RESI-10-01-01, version: November 2012, indicated the evaluation of the restraint consisted of a restraint reassessment to be competed at a minimum of quarterly. Resident #035's plan of care indicated the resident required the use of two, three-quarter length bed rails to be in place as a physical restraint. The most recent (quarterly) restraint assessment for resident #035 was completed on January 24, 2014. Interview with the Acting DOC confirmed the restraint reassessment was not completed quarterly as indicated in the home's restraint policy. [s. 29. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. O. Reg. 79/10, s. 30 (2).

A) Resident #001's current plan of care directed staff to wear appropriate personal protective equipment (PPE) when providing care due to the presence of an Antibiotic Resistant Organism (ARO). Staff were observed not wearing PPE on all dates of this inspection. The Acting DOC confirmed that the Clinical Coordinator had discontinued the intervention several months previously but had failed to document in the health record. [s. 30. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following were satisfied: 2. Alternatives to restraining the resident had been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.

A) During Stage one of the RQI, resident #035 was observed in bed with two, three-quarter bed rails in the raised position. The bed frame was noted to be approximately three feet from the floor and there were no fall mats in place. Resident #035's most recent plan of care identified the resident had a physical restraint of two full bed rails, to be placed in the raised position when the resident was in bed, and was to be monitored hourly. Documentation confirmed the restraint was implemented to prevent the risk of falls when the resident was in bed. A review of the restraint assessment, completed in January 2014, had a section E that included alternatives that would have been trialed, evaluated and directed that the outcomes would be documented in the resident's progress notes. This section E of the assessment had not been completed. A review of the clinical record did not include documentation of alternatives trialed. Interview with the acting DOC and the registered staff confirmed the form was not completed in its entirety and that the plan of care did not include alternatives considered and trialed prior to the use of the bed rails being used as a restraining device. The Acting DOC and registered staff both confirmed utilizing a high/low bed, placing the bed in the lowest position, and using fall mats would be standard practice alternatives considered to address the risk. (511)

B) Two full bed rails were being used in the raised position for resident #001 when in bed, at the family's request. The only restraint assessment completed was in December 2014 for the bed rails and indicated that no other alternatives had been considered or tried. This information was confirmed by registered staff. (146) [s. 31. (2) 2.]

WN #11: 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 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and cleaning of dentures.

In December 2014 at 0800 hours resident #600 was observed to be awake, dressed, out of bed with dry dark debris around the inner edge of their lips. Resident #600's upper dentures were in place and the bottom dentures were found dry, placed in a soaking tray. The plan of care identified that oral care was to be provided in the morning and at bedtime and dentures were to be soaked in solution overnight. In an interview with the registered nursing staff, at 0900 hours, it was stated that morning care was provided by the night shift and it was not documented in the personal support worker flow sheets that oral care was provided during the shift. It was confirmed by the registered nursing staff that oral care was not provided in the evening as dentures had not been soaked in a solution overnight and that morning care was not done as resident #600's tooth brush appeared dried and unused. [s. 34. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was served using methods that preserved taste, nutritive value, appearance and food quality at the lunch meal December 8, 2014.

A staff member who assisted resident #300 was observed mixing the resident's food together on the plate without the permission of the resident; the resident was unable to voice their preferences. The PSW (student), that assisted the resident with eating, confirmed that they mixed the resident's food together and stated they were just doing what they were told to do. The resident's plan of care and the home's policy for meal service did not direct staff to mix the resident's food together. Mixing the food together altered the taste, appearance and food quality of the meal. [s. 72. (3) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information for the purposes of subsections (1) and (2) was posted: (k) copies of the inspection reports from the past two years for the long-term care home.

During the initial tour of the home on December 9, 2014, it was observed that the home had not posted the four most recent inspection reports dated between September 2013 and February 2014. This information was confirmed by the Acting Administrator. [s. 79. (3) (k)]

WN #14: 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 failed to ensure that all hazardous chemicals were kept inaccessible to residents at all times.

On December 8, 2014, at 1023 hours the "Dirty Utility Room" on the Fennell home area was found unlocked and unattended by staff. The cupboards in the utility room were found unlocked and could be easily accessed by residents. Two bottles of ED disinfectant cleaner were found in the cupboard. The bottles of disinfectant directed staff to use goggles and gloves when handling the product. [s. 91.]

WN #15: 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):
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).

Findings/Faits saillants :

1. The licensee shall ensure that the Director was 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): 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Resident #400 was sent to hospital in 2014 after a medication incident of the wrong medication was administered to the wrong resident. The licensee sent in the Critical Incident Report two days later rather than the next business day. [s. 107. (3) 5.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

During Stage one of the RQI, resident #035 was observed in bed with two, three-quarter bed rails in the raised position. Resident #035's most recent plan of care identified the resident had a physical restraint of two full bed rails, to be placed in the raised position when the resident was in bed, and monitored hourly. A review of the restraint record flow sheets from November 1-31, 2014 indicated the resident was not monitored hourly on the following days/shifts:

November 1, 2, 5, 31, 2014/day shift (0700-1400 hours)
November 31, 2014/evening shift (1500-2200 hours)
November 2, 17, 18, 19, 22, 28, 29, 31, 2014/night shift (2300-0600 hours)

December 1, 3, 5, 2014/ day shift (0700-1400 hours)
December 4, 6, 7, 8, 2014/evening shift (1500-2200 hours)

Interview with two PSW's, who provided care during the stage one observation, confirmed the staff use the restraint record flow sheet to document their observation of the hourly checks of resident's with restraints, including resident #035. An interview with the Acting Administrator confirmed the flow sheets did not indicate the resident was checked hourly and stated the sheet was to be completed when the hourly observation of the resident was completed by the PSW's. [s. 110. (2) 3.]

WN #17: 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 (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) that was secure and locked, (iii) that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy.

Two topical medications prescribed for resident #004 were observed to be on the bathroom counter of the resident's room on three separate days in December 2014. In December 2014, the RPN confirmed that the medications should not have been left in the resident's room. The medications were stored improperly. [s. 129. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any controlled substance that was to be destroyed and disposed of was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

A) On a day in December 2014, the discontinued narcotic cupboard was observed. The drugs were stored in a locked storage room inside a stationary wooden cupboard with a single lock that secured the cupboard door. However, there was a 5 cm wide open mail slot on the door of the cupboard through which a hand could slide. The Acting DOC in attendance stated the open slot was for the staff to deposit the discontinued controlled medications without actually opening the door. The contents of the cupboard were viewed only once per month by the Acting DOC when drug destruction was done. The discarded narcotics were not protected by a double lock system. [s. 136. (2) 2.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following immunization and screening measures were in place: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The Infection Prevention and Control Confirmation Checklist, completed by the home on November 21, 2014 and provided to the LTC Inspection Team Lead at the entrance conference on December 8, 2014, identified the home was not offering residents immunizations against pneumoccoccus, tetanus and diptheria. The Acting Director of Care confirmed that the home was not currently offering those immunizations to residents. [s. 229. (10) 3.]

Issued on this 30th day of January, 2015

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511), BARBARA NAYKALYK-HUNT (146), KELLY HAYES (583), MICHELLE WARRENER (107), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_250511_0029
Log No. / Registre no:	H-001642-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 20, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HAMILTON 90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

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)

Linked to Existing Order / Lien vers ordre existant: 2013_214146_0050, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that care set out in the plan of care is provided to resident's #005, #600, #043, #301. Specifically, the plan shall include actions needed to ensure the above residents receive their nutrition, hydration and treatment needs as specified in the plan. The plan will include a process for sustainability to ensure that the home can maintain a long term goal of compliance (i.e should the care needs of the resident change, the plan of care and care needs of the resident are congruent and implemented as such). The plan shall be submitted electronically to Robin Mackie, LTC Homes Inspector, Ministry of Heath and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at Robin.mackie@ontario.ca by the end of business day on February 28, 2015

Grounds / Motifs :

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

A) Resident #301's plan of care required pudding consistency and thickened fluids with meals. The resident was provided honey consistency, thickened fluids (as confirmed by staff assisting the resident with eating) at the lunch meal in December 2014. The resident had a wet cough after consuming their thickened fluids and was coughing repeatedly throughout the meal. Staff stated that they did not observe the resident with the same cough at the breakfast meal that day. The resident was not provided the correct consistency of thickened fluids as outlined in their plan of care.(107)

B) A review of the plan of care for resident #600 identified they were at a high nutritional risk and required a high calorie, high protein specific meal. On a day in December 2014, during a meal observation, resident #600 was not provided their high calorie, high protein meal. It was confirmed with the Dietary Aid (DA) that the intervention was documented on the diet list sheets, which the DA references during meal service, and that the high calorie, high protein meal was not provided as specified in the plan. In an interview with the Registered Dietitian (RD) in December 2014, it was confirmed that resident #600 was assessed at high nutrition risk and required a high calorie, high protein meal to meet their nutrition requirements.

C) A review of the plan of care indicated resident #005 was at high nutrition risk due to significant weight loss, poor intake and altered skin integrity, and was to be provided a specified supplement with each meal for added calories and protein. During lunch service on a day in December 2014, resident #005 was provided only half of the specified supplement by the registered nursing staff. In an interview with the registered nursing staff they confirmed resident #005 was to receive the full amount of the specified supplement, as directed by the medication administration record, and that the nutritional supplement was not provided as specified in the plan.

D) During lunch service on a day in December 2014, resident #005 was not brought to the dining room, was observed to be awake in bed and when asked by inspector #583 if they were hungry, they responded "yes". In an interview with the registered staff and non registered staff it was stated that resident #005 eats a meal in bed because they have altered skin integrity. A review of the plan of care identified that resident #005 was to be transferred into bed after their meal, daily to provide pressure relief. In an interview with the registered nursing staff on a day in December 2014 it was confirmed the care provided was not as specified in the plan. (583)

E) A review of the clinical record indicated resident #043 had been referred and seen by the RD for swallowing difficulty on a specific day in 2014. The RD recommended nectar thickened fluids and indicated the order was written, the plan of care updated, and the RD would continue to monitor the resident's response. The resident's plan of care was updated by the RD, on the same day in 2014, and indicated nectar thickened fluids. After the specific date that the RD had updated the care plan in 2014, the progress notes indicated that the

resident was noted to have a cough when they consumed thin fluids and a request for the doctor to assess was indicated in the doctor's book. Approximately one month later a cup that was half full of water, that had not been thickened, was observed at the resident's bedside. Interview with two PSW's confirmed the resident had continued to receive water that had not been thickened. Interview with the RD confirmed the care set out in the plan of care for resident #043 was not provided to the resident as specified in the plan. (511)

F) A review of resident #005's plan of care indicated the resident had altered skin integrity that required a treatment and dressing change every two days during the month of December 2014. A review of the December 2014 electronic Treatment Authorization Record (eTAR) indicated the dressing was changed every three days. Interview with the registered staff confirmed the dressing was not changed as set out in the plan of care. (511)

(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Robin Mackie

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