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

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Inspection de soins de longue durée

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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
Jun 5, 2017	2017_615638_0010	005876-17	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 TIMMINS
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642), LAUREN TENHUNEN (196), LINDSAY DYRDA (575), SYLVIE BYRNES (627)

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): April 18-21 and 24-28, 2017

The following intakes were completed during this Resident Quality Inspection:
-One log was related to CO #001 from Inspection report #2016_391603_0018 s. 6 (4) of the Long-Term Care Homes Act, 2007 (LTCHA), regarding inconsistent skin and wound assessments,
-One log was related to CO #002 from Inspection report #2016_391603_0018 s. 8 (3)

of the LTCHA, 2007, specific to the home's 24 hour RN staffing plan,
-One log was related to CO #001 from Inspection report #2016_391603_0016 s. 8 (1) of the LTCHA, 2007, regarding insufficient staffing and not meeting residents' assessed needs,
-One log was related to a critical incident the home submitted regarding a complaint served to the home specific to funding and insufficient staffing,
-Two logs were related to critical incidents the home submitted regarding a fall in which the resident was sent to hospital,
-One log was related to a critical incident the home submitted regarding a fall in which the resident had a significant change in their health status,
-One log was related to a critical incident the home submitted regarding improper care which resulted in actual harm to the resident,
-One log was a complaint submitted to the Director which was related to concerns related to a lack of funding and insufficient staffing which impacted resident care, and
-One log was a complaint submitted to the Director which was related to insufficient staffing which impacted resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), Resident and Program Manager (RPM), Social Worker (SW), Dietary Manager (DM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitians (RD), Dietary Aids (DA), physicians, residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
13 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2016_391603_0018	638
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #001	2016_391603_0016	196
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2016_391603_0018	196

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview with Inspector #638, Dietary Aid (DA) #128 stated that they had witnessed an incident of neglectful care in February 2017. They stated that they were setting tables in one of the home areas when resident #007 requested assistance to be toileted by staff. The DA stated that they notified RN #129 that the resident requested assistance to be toileted and RN #129 refused to provide assistance and left the DA alone with resident #007. DA #128 stated that they felt that this was an incident of neglect and wrote up a letter of the incident on the date of the incident, which was immediately submitted to the DOC. DA #128 stated that they were never interviewed or followed up with related to the incident of alleged neglect.

The Inspector reviewed the letter submitted to the DOC which described the events as stated by DA #128. It was documented in the letter that the resident proceeded to toilet independently while their fall intervention alarm sounded.

In a review of resident #007's care plan, Inspector #638 identified that the resident required physical assistance for transfers due to their high fall risk.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" - RC-02-01-02 last revised April 2016, indicated that anyone who suspected, witnessed or became aware of an incident of neglect would report it immediately to the designate. In addition the home's policy indicated that the designate who became aware of an incident of alleged, suspected or witnessed neglect was required to notify the Director.

In an interview with Inspector #638, the DOC stated that they believed the letter which alleged neglect was submitted to the DOC one day after the incident had occurred, however, there was no documentation indicating when the letter was received. The DOC then stated that the allegation of neglect was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, each resident who is incontinent and has been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

Inspector #196 received a written note from RPN #138. The note indicated that one of the home areas was one PSW short during their day shift and as a result, staff were unable to complete all the residents' required care. The note identified that resident #019 had not received assistance with their predetermined continence care routines on two consecutive instances, resident #020, #021 and #022's predetermined continence care routines had not been provided on one occasion and resident #018's incontinent product had not been checked and changed on one occasion as per their predetermined continence care routines. RPN #138 identified that the shortage of staff was common and has created workload issues.

The care plans for the above listed residents identified that continence care routines were supposed to be implemented as follows; Resident #018's care plan interventions directed staff to check the resident's continence product on day shift on two separate occasions. While resident #019, #020, #021 and #022's care plans all included interventions to toilet the residents on day shift approximately every two hours as per their assessed needs.

Inspector #638 received a written note from PSW #135 which indicated that specific toileting routines were not completed due to staffing shortages. The note indicated that one of the home areas was working one PSW short during the evening shift. It was further identified that ten residents (resident #023, #024, #025, #026, #027, #028 #029 #030, #031 and #032) were not provided with their respective predetermined continence

care interventions as per their assessed needs. In an interview with Inspector #638, PSW #135 stated that this care had not been provided due to a shortage of front line staff, which effected workload and timeliness of care provided. PSW #135 stated that toileting routines were commonly missed due to the prioritization of care when working short a PSW on each unit.

The care plans for the above listed residents identified that continence care routines were supposed to be implemented as follows; Resident #023, #024, #025, #026, #028, #029, #030, #031 and #032 each required assistance to have their continence care needs met and had scripted toileting routines throughout each shift. Resident #027 required their continence product to be checked and changed at specific times throughout the afternoon shift. In an interview with PSW #135, none of the interventions laid out within each resident's respective toileting routines was provided, due to insufficient staffing of PSWs.

In an interview with Inspector #196 and Inspector #638, PSW #126, PSW #135, RPN #138 and RN #110 each stated that when a resident's toileting routine had not been completed, staff document the care as "N/A", which indicated that the care was not provided. Inspector #196 and Inspector #638 reviewed the documented care for each of the 15 residents listed above. All care in the previously specified times had been documented as "N/A" (not done).

In an interview with Inspector #196, the DOC stated that if PSWs were unable to complete resident care as per their assessed needs, they were expected to notify the RPN working in that home area, The RPN would then report and discuss workload concerns with the RN and create a plan to complete all required care when short staffed. [s. 51. (2) (d)]

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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

During a review of the home’s medication incidents from January and February 2017. Inspector #575 identified a medication incident which occurred in January 2017. During this incident, resident #015 received an extra dose of medication. The medication incident form indicated that the resident received their regular dose of medication at two different times throughout the day, however, an additional dose was administered in error The medication incident form stated that the resident’s vital signs were stable.

Inspector #575 reviewed resident #015’s health care record. Resident #015's vital signs were not documented and there was no progress note documenting the incident. Furthermore, resident #015's electronic Medication Administration Record (eMAR) did not indicate that a medication error had occurred.

The home’s policy titled “Medication Safe Practice, Assessment Tool”, indicated that staff must adhere to the six rights of medication administration which included: the right medication, dose, resident, route, time, and documentation. The policy also indicated that the person administering a medication would record the resident’s status prior to the medication administration, the medication administered, the time administered, the dosage of the medication and the route it was administered.

In an interview with Inspector #575, the Administrator stated that the vital signs were not documented and there were no progress notes regarding the medication incident in January 2017, for resident #015. In an email to the Inspector, the DOC identified that staff did not document their assessment of the resident, nor follow the standards of

practice. The DOC stated that the staff member did not follow the home’s policy. [s. 8. (1) (b)]

2. A Critical Incident System (CIS) report was submitted to the Director in February 2017. The CIS report alleged an incident of improper care toward resident #002 from a specific procedure, which resulted in actual harm to the resident.

Inspector #627 reviewed the home’s internal investigation notes which indicated that the DOC had interviewed RN #113 and RPN #114 related to the incident of improper care. The notes indicated that RN #113 and RPN #114 had performed a specific procedure on resident #002 and although there had been no indication the intervention had been implemented appropriately, they continued with the procedure as there was no resistance felt.

The Inspector reviewed a letter submitted to the home by a family member of resident #002. The letter alleged that in February 2017, RN #113 attempted to change resident #002’s specific intervention and had placed the intervention improperly and completed their task with the intervention situated in the wrong location which resulted in actual harm to the resident. As a result resident #002 was hospitalized due to the harm that came from the intervention RN #113 provided.

In a review of the home's policy specific to the intervention implemented, staff were to implement the intervention and ensure that an identified outcome occurred.

During a telephone interview with the Inspector, RN #113 stated that they had assisted RPN #114 with the specific intervention provided to resident #002. At the time, there had been no indication that the intervention had been implemented appropriately, however, they had assumed that the intervention was in place. RN #113 stated that they reported to the oncoming shift that the expected outcomes from the intervention had not occurred and to monitor the resident.

In an interview with the Inspector, the DOC stated that when this specific intervention was implemented, the intervention should not be fully implemented if there was no indication that the intervention was appropriately placed to not cause harm to the resident. The DOC confirmed that the home's policy reviewed by the Inspector should have been complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview with Inspector #638, DA #128 stated that they witnessed what they considered an incident of neglect when RN #129 did not assist resident #007 with their required toileting needs. The Inspector also reviewed a letter written and submitted to the DOC by DA #128 after the incident of alleged neglect in February 2017. Please refer to WN #1 for details.

In an interview with Inspector #638, RN #129 stated that they were notified by DA #128 in February 2017, that resident #007 requested assistance to be toileted. RN #129 did not recall how they responded to DA #128, however, they left the home area shortly after the request for assistance with no other direct care staff available. RN #129 was unable to recall if they notified another staff member that the resident required assistance or why they had to leave that home area. RN #129 stated that they were not interviewed related to the incident until a few weeks later and they were not notified nor put on a leave, pending the investigation.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" - RC-02-01-03 last revised April 2016, indicated that, upon being made aware of an allegation of neglect, management would immediately advise the employee that they were being removed from the work schedule, pending investigation.

In an interview with Inspector #638, the DOC stated that the letter related to the allegations of neglect was submitted one day after the incident in February 2017. The DOC then stated that they initiated their internal investigation one or two days after they became aware of the alleged incident of neglect. The DOC stated after they became aware of the allegations of neglect, RN #129 was not put off pending the investigation and they worked in the home in the capacity of a RN. [s. 20. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Dietitian who was a member of the staff of the home was on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During a record review by Inspector #638, resident #009 was identified as having weight loss. During a staff interview, the Inspector was informed by RPN #138 that there were no weight gain interventions in place for resident #009 to address their low body mass index (BMI).

Inspector #627 reviewed the clinical record for resident #009 and identified that the resident's specific assessments and interventions were not consistent with one another. Please refer to WN #7 for details.

During an interview with the Inspector, Registered Dietitian (RD) #112 stated that there had been a lapse of Dietitian's in the home. The home's Dietitian had resigned in February 2017, and RD #112 had started during April 2017. In the interim, the home had utilized two part time Dietitians.

Inspector #627 reviewed the RD on-site hours for the month of March 2017. The on-site hours record indicated that RD #115 completed 42 hours of on-site duties and RD #122 completed 19 hours of on-site duties during the month of March 2017. The monthly amount of hours during March 2017, equated to a total of 61 hours on-site.

In an interview with Inspector #627, the DOC stated that the home's occupancy rate for the month of March 2017, was between 177 and 180 residents. The DOC stated that based on the occupancy of the home, the required number of RD on-site hours for the month of March 2017, was 90 hours.

The Inspector interviewed the Administrator, who stated that the required number of RD on-site hours for the month of March 2017, had not been met as per the requirements within the Ontario Regulation (O. Reg.) 79/10. The Administrator then stated that the combined on-site hours between RD #115 and RD #122 had only equated to a total of 61 hours of on-site duties. [s. 74. (2)]

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 a Registered Dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies, that was secure and locked.

Inspector #196 observed an unattended resident care cart located inside resident #009's room on April 25, 2017, at 0910 hours. The care cart had several labelled prescription topical medications left unsecured. The cart contained one tube of medication which was identified as resident #033's prescribed ointment and two other containers of medication; one container was identified as resident #034's ointment, while the other was identified as resident #035's ointment.

In an interview with Inspector #196, PSW #140 stated that resident care carts which housed topical medications were to be stored in the locked shower rooms or utility rooms when not in use in order to minimize the risk of harm to residents.

The home's policy titled "The Medication Storage" Policy 3-4, last revised February 2017, indicated that all medications were to be safely stored and supervised in accordance with the applicable legislation.

Inspector #196 interviewed the DOC who stated that resident care carts containing topical medications were expected to be stored in a locked area when not in use. The resident care carts with medicated ointments on them, should not be left in a resident's room when unattended. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

During a record review by Inspector #638, resident #009 was identified as having had weight loss and a low BMI.

Inspector #627 reviewed resident #009's health care records and identified a medical order created in February 2017. The order directed staff to provide the resident with a specific amount of nutritional supplement twice a day during the medication pass. The Inspector also noted a medical order created in April 2017, which directed staff to increase the amount of the nutritional supplement administered during one of the medication administration times and to continue administering the originally prescribed amount during the other administration time.

The Inspector reviewed resident #009's eMAR on April 25, 2017, which identified that the resident had still been receiving the originally prescribed amount of nutritional supplement during both administration times.

In an interview with Inspector #627, RPN #117 stated that the eMAR had not been updated when the order for the nutritional supplement was changed in April 2017. RPN #117 stated that the resident had only received the amount of supplement originally ordered in February 2017, as opposed to the increased amount of nutritional supplement which was ordered in April 2017.

In an interview with Inspector #627, the DOC stated that the eMAR had not been updated with the new order written in April 2017, and that resident #009 had not received the ordered nutritional supplement as prescribed. [s. 131. (2)]

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 drugs are administered to resident #009 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

During a record review by Inspector #638, resident #010 was identified as having a new area of altered skin integrity within 30 days after their admission to the home.

Inspector #638 reviewed resident #010’s health care records and identified that the resident's admission head to toe assessment had been completed one day after

admission, by RPN #117. The resident was assessed as having no areas of altered skin integrity.

The Inspector reviewed a “Interdisciplinary Resident Assessment” completed by physician #119 four days after the completed head to toe assessment, which identified that resident #010 had an area of altered skin integrity which required specific interventions. The Inspector was unable to locate any other documentation related to resident #010’s area of altered skin integrity until ten days after the aforementioned assessment completed by physician #119.

Inspector #638 reviewed the “Referral – Skin – Wound Care Champion” form completed by RN #120 which indicated that the resident had an existing skin issue with failure to improve, which indicated that resident #010's area of altered skin integrity had worsened since their admission to the home.

In an review of the “Skin – Weekly Wound Assessment” completed 15 days after physician #119's assessment, resident #010 was assessed as having one "acquired" (post admission to home) area of altered skin integrity. The Inspector also reviewed the “Skin – Weekly Wound Assessment” completed one month later. The resident was identified as having one "inherited" (pre-admission to home) area of altered skin integrity.

In an interview with Inspector #638, physician #119 stated that prior to their admission, resident #010 was assessed as having an area of altered skin integrity.

In an interview with Inspector #638, the Clinical Coordinator (CC) stated that the completed documentation related to resident #010’s skin integrity assessments were not clear and did not provide a clear and concise depiction of the resident’s health status.

Inspector #638 conducted an interview with the DOC, who stated that the completed assessments did not complement one another and it was difficult to determine what resident #010’s health status was at the time of their admission.

A WN has been issued for this finding related to CO #001 from Inspection #2016_391603_0018 as the non compliance had been identified prior to the compliance date of October 18, 2016. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director in February 2017. The report alleged an incident of improper care toward resident #002 in February 2017, which resulted in actual harm to the resident due to a specific intervention being implemented. Please refer to WN #3 finding "2." for details regarding the incident.

Inspector #627 reviewed resident #002’s health care records. The Inspector identified that the specific intervention was to be implemented as per the Treatment Administration Record (TAR) on a specific day in February 2017, however, there was no documentation indicating if the care had been provided or not. The Inspector reviewed the progress notes for resident #002 and identified one day after the specific intervention was supposed to be provided, RPN #114 documented that resident #002 was due for their specific intervention to be implemented. The note further identified that the physician had been called as the resident exhibited specific signs and symptoms of concern after the implementation of the specific intervention. Inspector #627 was unable to identify documentation indicating the date or time the specific intervention had been implemented.

During an interview with the Inspector, RPN #113 stated that when a specific intervention was implemented staff should document specific observations, outcomes and how the resident tolerated the procedure. They confirmed that there was no documentation regarding the specific intervention provided for resident #002.

A review of the home’s internal investigation notes indicated that the DOC interviewed RN #113 and RPN #114 related to the incident of improper care. There was no date or time indicated in the home’s internal investigation notes that identified when resident #002's specific intervention had been implemented.

During an interview with Inspector #627, the DOC stated that all provision of care was to be documented in the progress notes and that any treatment was to be documented in the TAR (as required). The DOC stated that there was no documentation identifying when resident #002's specific intervention had been implemented and how the intervention was tolerated. [s. 6. (9) 1.]

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.

During a record review by Inspector #638, resident #009 was identified as having had a weight loss. As well, during a staff interview, the Inspector was also informed by RPN #138 that there were no weight gain interventions in place for resident #009 to address the resident's low BMI.

Inspector #627 reviewed resident #009's health care record which identified that the resident had had a significant weight change, where the resident had a 12.3 per cent decrease in their weight within the six month period. During the same review, the Inspector identified an order from RD #115, dated in April 2017, regarding resident #009's weight loss. The order directed staff to; increase the resident's nutritional supplement during the evening medication pass and to continue administering the same amount of nutritional supplement during the morning medication pass. The Inspector was unable to identify any assessments or reassessments completed in regards to resident #009's weight loss since the new intervention was implemented in April 2017.

During an interview with Inspector #627, RD #112 stated that anytime a resident had a significant weight change, an assessment should be completed and documented in the progress notes. The documentation should have included the resident’s current weight and current BMI, the history of their weight loss, their nutritional status, their goal weight range, their hydration status, what interventions were in place and interventions in the care plan regarding the assistance required for nutrition and hydration. The RD further stated that the reassessment and resident's responses to current interventions should have been documented in the progress notes as well. RD #112 was unable to provide the Inspector with any formal documentation related to the assessment, reassessment, or resident’s responses to interventions related to the new order which increased resident #009's dose of nutritional supplement in April 2017.

During a telephone interview with the Inspector, RD #115 stated they had increased resident #009’s nutritional supplement during one of the medication passes, however, they had not documented assessments or reassessments, or the resident’s response to interventions when that had been implemented in response to the resident's weight change. [s. 30. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who has fallen, had been assessed and, if required, a post fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director in January 2017, related to an incident where resident #007 had fallen and sustained multiple injuries. After the fall, resident #007 was sent to the hospital for assessment.

Inspector #638 reviewed resident #007’s progress notes which identified that the resident had sustained a fall in January 2017. The resident was sent to hospital for assessment and their return was documented one day after they were sent to the hospital.

The Inspector reviewed resident #007's health care record and the completed assessments related to their fall in January 2017. The Inspector was unable to identify a completed post fall assessment for resident #007 on the date of the fall. The Inspector identified a post fall assessment which had been initiated two days later. The post fall assessment completed by RN #108 on gave no indication as to the date and time of the fall being assessed. The Inspector was unable to determine if the completed post fall assessment in February 2017, was related to the fall which occurred two days prior, as the documented vital signs were from various dates which did not coincide with the date of the incident.

In an interview with Inspector #638, RPN #109 stated that when a resident has fallen, a full post fall assessment was expected to be completed immediately following the

incident. The RPN further indicated that the post fall assessment should be completed in entirety to ensure that specific required details were documented. RPN #109 reviewed the post fall assessment completed in February 2017, with the Inspector. They stated that it was not clear if the post fall assessment was related to the incident in January 2017, since the assessment was lacking information related to the date and time of the incident.

Inspector #638 interviewed RN #110 who stated that following a fall, staff were required to complete a post fall assessment which was located on PCC assessments.

The home's policy titled "Falls Prevention and Management Program" RC-06-04-01 last revised May 2016, indicated that staff were expected to complete a post fall assessment as a follow up to each incident in which a resident had sustained a fall.

In an interview with Inspector #638, the DOC stated that following a fall, staff should immediately complete a post fall assessment. The DOC then stated that staff should ensure that all assessments were completed in entirety to ensure that all of the pertinent information was documented. The DOC stated that it appeared as though the post fall assessment completed in February 2017, was related to the fall which occurred two days prior in January 2017, however, it was not definitive because the date of the incident the assessment pertained to had not been documented. [s. 49. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included an alternative choice of vegetables at lunch and supper.

During an interview, resident #010, #012 and #013 complained that the home's food quality was lacking.

Inspector #627 observed the lunch dining service on one of the home areas on April 20, 2017. Inspector # 627 noted that the first menu option included; hot turkey on wheat, wax beans, and iced banana cake and the second menu option included; tuna salad sandwiches with macaroni salad and chilled tropical fruit.

The Inspector reviewed the home's 21 day winter 2016, and 2017, menu cycle. The Inspector identified three occasions where an alternate vegetable had not been offered during the lunch time dining service. These instances were; Friday of the Week 1 menu, Tuesday of the Week 2 menu and Thursday of the Week 3 menu.

In an interview with Inspector #627, the DM stated that an alternate vegetable had not been offered during the lunch dining service on the three aforementioned occasions (one being the April 20, 2017, lunch service) in the winter 2016, and 2017, menu cycle. [s. 71. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In an interview with Inspector #575, the Administrator stated that a review of all medication incidents and adverse drug reactions was completed quarterly during the home's Professional Advisory Committee (PAC) meetings.

Inspector #575 reviewed the home's PAC meeting minutes. The Inspector noted that the last PAC meeting minutes were dated April 25, 2016.

During an interview with Inspector #575, the Administrator stated that there had not been a quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since April 25, 2016. The Administrator stated that the home did not have a pharmacist from June 2016, to March 2017, therefore, the meetings did not take place. [s. 135. (3)]

WN #13: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Inspector #575 observed a medication administration pass on April 20, 2017, at 1110 hours on one of the home areas. The Inspector observed RPN #102 prepare and administer medications to resident #015. The RPN then prepared the medications for resident #016, which involved crushing the medication. RPN #102 entered resident #016’s room, mixed the crushed medication with yogurt and administered it to the resident with a spoon. The RPN was then observed providing medications to a third resident. Throughout their entire medication pass, the RPN was observed documenting the administration of the medications on the resident’s eMAR using a touch screen monitor. No hand hygiene was observed throughout the medication pass for the three aforementioned residents.

During an interview with RPN #102, they stated that they performed hand hygiene prior to the medication pass. When asked what the home’s policy was regarding hand hygiene during medication pass, the RPN indicated that they should wash their hands between resident interactions.

The Inspector reviewed the home's policy titled "Hand Hygiene" last updated September 2016. The policy directed staff to perform hand hygiene before and after contact with any resident, their body substance or items contaminated by them, before and after feeding a resident, and after touching any commonly touched surfaces such as keyboards, doorknobs, elevator buttons, or touch computer screens.

In an interview with the CC (Infection Control Lead), they indicated that when the RPN mixed and administered resident #016’s medication they should have performed hand hygiene. [s. 229. (4)]

2. The licensee has failed to ensure that a resident was monitored for symptoms of infection on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During a record review, resident #004 was identified as having acquired a respiratory infection.

Inspector #642 reviewed resident #004's health care records and identified that the resident was diagnosed by a physician as having a respiratory infection in March 2017. The resident was maintained on isolation for eight days.

Inspector #642 interviewed RPN #125, RPN #137 and RN #120. Each staff member stated that when a resident was on respiratory isolation that they were required to document the resident's signs and symptoms each shift. RN #120 stated that this was recorded in the progress notes or on Point Click Care (PCC) in the vital signs section until the resident's infection has been resolved.

The Inspector reviewed the resident’s health care records and the Inspector identified missing documentation for the monitoring of resident #004's respiratory infection during the night shift on one date, the day and night shift on a second date, the day and night shift on a third date, as well as the night shift on a fourth date in March 2017.

In an interview with Inspector #642, the CC stated that they were unable to locate any documentation related to the monitoring of resident #004's symptoms on the shifts previously identified as missing by the Inspector. The CC stated that staff were required to document each shift when a resident was on isolation for a respiratory infection. [s. 229. (5) (a)]

Issued on this 8th day of June, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8	Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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) : RYAN GOODMURPHY (638), AMY GEAUVREAU (642), LAUREN TENHUNEN (196), LINDSAY DYRDA (575), SYLVIE BYRNES (627)

Inspection No. / No de l'inspection : 2017_615638_0010

Log No. / Registre no: 005876-17

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

Report Date(s) / Date(s) du Rapport : Jun 5, 2017

Licensee / Titulaire de permis : EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : EXTENDICARE TIMMINS
15 Hollinger Lane, Box 817, Schumacher, ON, P0N-1G0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kelly Roy

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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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the person who has reasonable grounds to suspect that any of the criteria laid out under s. 24 (1) of the LTCHA, 2007, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The plan shall include, but not limited to the following:

1. How the licensee will ensure that every incident, requiring immediate reporting, will be reported to the Director.

2. A tracking process to monitor each incident, which includes; the date of the incident, the date management became aware of the incident, when the incident was reported to the Director and when the internal investigation was initiated and completed (including the dates investigations were undertaken and who was apart of the investigation).

3. Who will be responsible to review and ensure that each incident, requiring immediate reporting, is reported to the Director.

The plan must be faxed to the attention of LTCH Inspector Ryan Goodmurphy, at (705) 564-3133. The plan is due on June 30, 2017, and the order is to be complied by July 31, 2017.

Grounds / Motifs :

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

In an interview with Inspector #638, Dietary Aid (DA) #128 stated that they had witnessed an incident of neglectful care in February 2017. They stated that they were setting tables in one of the home areas when resident #007 requested assistance to be toileted by staff. The DA stated that they notified RN #129 that the resident requested assistance to be toileted and RN #129 refused to provide assistance and left the DA alone with resident #007. DA #128 stated that they felt that this was an incident of neglect and wrote up a letter of the incident on the date of the incident, which was immediately submitted to the DOC. DA #128 stated that they were never interviewed or followed up with related to the

incident of alleged neglect.

The Inspector reviewed the letter submitted to the DOC which described the events as stated by DA #128. It was documented in the letter that the resident proceeded to toilet independently while their fall intervention alarm sounded.

In a review of resident #007's care plan, Inspector #638 identified that the resident required physical assistance for transfers due to their high fall risk.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" - RC-02-01-02 last revised April 2016, indicated that anyone who suspected, witnessed or became aware of an incident of neglect would report it immediately to the designate. In addition the home's policy indicated that the designate who became aware of an incident of alleged, suspected or witnessed neglect was required to notify the Director.

In an interview with Inspector #638, the DOC stated that they believed the letter which alleged neglect was submitted to the DOC one day after the incident had occurred, however, there was no documentation indicating when the letter was received. The DOC then stated that the allegation of neglect was not reported to the Director.

During previous inspections (#2014_140158_0011, #2016_264609_0004 and #2016_391603_0017) a Written Notification (WN) was issued to the home on July 14, 2014, and two Voluntary Plans of Correction (VPC) were issued to the home on March 1, 2016 and November 2, 2016, respectively. The decision to issue a compliance order was based on the severity which indicates potential risk of actual harm of the residents of the home. Furthermore, the home's compliance history identified ongoing non compliance related to this section, which included two VPCs and one WN previously issued within the past 36 months. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall develop and implement the following:

1. A process to ensure that each resident requiring assistance to maintain their continence or be continent some of the time receives the assistance required as per their assessed needs.

2. An auditing process that will identify when staff are not able to provide care as per the resident's assessed continence needs so that corrective actions can be taken.

3. A multidisciplinary process which ensures clear communication between front line staff (PSWs, RPNs and RNs) and management when continence care needs are not being met.

Grounds / Motifs :

1. The licensee has failed to ensure that, each resident who is incontinent and has been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

Inspector #196 received a written note from RPN #138. The note indicated that one of the home areas was one PSW short during their day shift and as a result, staff were unable to complete all the residents' required care. The note identified that resident #019 had not received assistance with their predetermined continence care routines on two consecutive instances, resident #020, #021 and #022's predetermined continence care routines had not been provided on one occasion and resident #018's incontinent product had not been checked and changed on one occasion as per their predetermined continence care routines. RPN #138 identified that the shortage of staff was common and has created workload issues.

The care plans for the above listed residents identified that continence care routines were supposed to be implemented as follows; Resident #018's care plan interventions directed staff to check the resident's continence product on day shift on two separate occasions. While resident #019, #020, #021 and #022's care plans all included interventions to toilet the residents on day shift approximately every two hours as per their assessed needs.

Inspector #638 received a written note from PSW #135 which indicated that

specific toileting routines were not completed due to staffing shortages. The note indicated that one of the home areas was working one PSW short during the evening shift. It was further identified that ten residents (resident #023, #024, #025, #026, #027, #028 #029 #030, #031 and #032) were not provided with their respective predetermined continence care interventions as per their assessed needs. In an interview with Inspector #638, PSW #135 stated that this care had not been provided due to a shortage of front line staff, which effected workload and timeliness of care provided. PSW #135 stated that toileting routines were commonly missed due to the prioritization of care when working short a PSW on each unit.

The care plans for the above listed residents identified that continence care routines were supposed to be implemented as follows; Resident #023, #024, #025, #026, #028, #029, #030, #031 and #032 each required assistance to have their continence care needs met and had scripted toileting routines throughout each shift. Resident #027 required their continence product to be checked and changed at specific times throughout the afternoon shift. In an interview with PSW #135, none of the interventions laid out within each resident's respective toileting routines was provided, due to insufficient staffing of PSWs.

In an interview with Inspector #196 and Inspector #638, PSW #126, PSW #135, RPN #138 and RN #110 each stated that when a resident's toileting routine had not been completed, staff document the care as "N/A", which indicated that the care was not provided. Inspector #196 and Inspector #638 reviewed the documented care for each of the 15 residents listed above. All care in the previously specified times had been documented as "N/A" (not done).

In an interview with Inspector #196, the DOC stated that if PSWs were unable to complete resident care as per their assessed needs, they were expected to notify the RPN working in that home area, The RPN would then report and discuss workload concerns with the RN and create a plan to complete all required care when short staffed.

During previous inspections, there were numerous unrelated non compliances within the past 36 months. The decision to issue a compliance order was based on the severity which indicates potential risk of actual harm of the residents. Furthermore, the scope of this non compliance was considered a pattern for residents who required assistance to maintain continence. Although, the compliance history was unrelated, the scope and severity had significant risk of

harm to residents requiring assistance with toileting routines. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 5th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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