Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Feb 21, 2017	2016_491647_0009	030275-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

GEORGIAN MANOR HOME FOR THE AGED
7 HARRIET STREET PENETANGUISHENE ON L9M 1K8

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

JENNIFER BROWN (647), SHIHANA RUMZI (604)

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): October 19, 20, 21, 24, 25, 26, 28, November 1,2,3,4,7,8,9, 10, 2016.

During the course of the inspection the following Complaint inspections were inspected:
007784-14 relating to duty to protect,
008445-14 relating to medication management, continence care, laundry, plan of care and recreational programs,
009292-14 relating to skin and wound care and plan of care,
015268-15 relating to Residents' bill of rights and plan of care,
024092-15 relating to duty to protect and skin and wound care,
032992-15 relating to duty to protect, nursing and personal support services, continence care, dining and snack service, menu planning, Residents' bill or rights and communications and response systems, and
005710-16 relating to plan of care.

During the course of the inspection the inspectors: reviewed clinical records, conducted a tour of the home, observations of meal services, medication administration, staff and resident interactions, provisions of care, reviewed staff training records, reviewed home's policies related to abuse and neglect of residents, medication administration, continence management and responsive behaviors and minutes from Residents' and Family Council.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Resident Care (DOC), Nurse Manager (NM), Wound/Skin Care Coordinator (WCC), Food Services Supervisor (FSS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Presidents of Residents' Council and Family Council, residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Family Council
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

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 all residents were protected from neglect by the licensee or staff.

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

Documentation review of an identified residents' progress notes and wound assessments identified six areas of alteration in skin integrity over several identified months in 2016.

The following concerns were noted during progress note review for the time period of November, 2015 – October, 2016:

1) Progress note dated August, 2016, indicated the identified resident had a specified alteration to skin integrity. A review of the wound assessment tool V1, Treatment Administration Record (TAR) and progress notes did not indicate care being provided for the above mentioned area until 16 days later. At the time of the inspection the area of skin breakdown had progressed.

2) A review of the wound assessment tool carried out in October, 2016, indicated skin breakdown to another specified area. No progress notes or skin assessment were found identifying skin break down to this area.

The inspector carried out an observation on the above mentioned residents' dressing change in November, 2016, with a Registered staff member and a direct care staff member. During the dressing change it was observed that the treatments were not administered as prescribed by the ET nurse for five of the wounds.

The inspector observed multiple scratch marks on a specified area on the resident with a dressing dated in November, 2016. The Registered staff member indicated when the site was exposed he/she was unaware of the scratches as he/she did not get report on the site or see a Point Click Care (PCC) note or skin assessment on the site. The direct care staff member indicated he/she had initially seen the site in November, 2016, when he/she was providing care and had reported it to the Registered staff member that morning.

A review of the PCC note and skin assessments did not identify the multiple large scratch marks on the resident as the inspector did not find documentation on PCC for the site until an identified date in November, 2016.

An interview with a Registered staff member indicated he/she worked on an identified date in November, 2016, on an identified unit and carried out the residents' dressings on that day. The Registered staff member indicated that he/she did not have the required supplies for three of the dressings and for two of the dressings, the nurse believed that he/she had administered the treatment properly.

An interview with the home’s Wound/Skin Care Coordinator (WCC) verified the skin breakdown to the lower extremity was not assessed on admission and was assessed five days later. The skin breakdown to the trunk was identified in October, 2016, when it had deteriorated and no prior progress notes or skin assessments was carried out, the second skin breakdown to the trunk was identified in August, 2016, in a progress note when the site had a blister at the time of the inspection, and now the site had worsened. The WCC indicated the staff did not follow the homes skin and wound care policy for the above sites and the identified residents' ulcers had gotten worse. When the WCC was informed of the findings of the observations carried out of the above mentioned residents' ulcers the WCC indicated that the home did not follow the ET nurses orders and did not provide the proper care to the resident. When the WCC was informed of the multiple scratches on the trunk of the resident, the WCC indicated staff are expected to carry out a skin assessment when a new skin issue is identified and verified there was no evidence of a progress note or skin assessment being carried out for the site. The WCC in closing indicated the home did not address residents' skin issues.

During an interview with the DOC the inspector informed him/her of the dressing observations as indicated above. The DOC indicated the direct care staff are to inform the Registered staff members immediately of any skin issue and a skin assessment is to be carried out. The DOC confirmed the staff in the home did poor documentation and an assessment was not done and did not follow the homes expectation related to carrying out skin assessment for the resident. When the DOC was informed of the findings of the multiple scratches on an identified area, the DOC indicated staff are expected to document the changes in the skin and home’s policy was not followed. In closing the DOC identified the dressing changes and dressings carried out by the staff and staff did not follow dressing orders by the ET nurse, assessment of the resident was not carried out post admission until five days later, the skin breakdown was discovered at a stage of deterioration with no previous assessment carried out, an identified area was assessed 16 days later, was now documented as deteriorated. The DOC identified the above concerns as neglect of the above mentioned resident.

The scope of the non-compliance is isolated.

The severity has negatively impacted the resident.

A review of the compliance history revealed the home had been issued non-compliances with voluntary plans of correction (VPC's) related to the Long-Term Care Homes Act, O. Reg c.8, s. (19)1:
-Inspection 2014_369153_00098 carried out August 17, 2014, home was served a VPC
-Inspection 2014_297558_0018 carried out November 6, 2014, home was served a VPC
[s. 19. (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. 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

A review of an identified residents' PCC progress notes from August, 2016, indicated multiple skin breakdown on trunk. After the initial identification there were no progress notes or skin assessment found with treatments being provided to the skin issues indicated above.

A review of the progress notes carried out in September, 2016, was the first time the skin breakdown had been addressed.

Interviews conducted with the home’s WCC and DOC indicated it is the home’s process is to ensure a skin and wound assessment is carried out to address any new skin and wound issues found on residents. The WCC and DOC confirmed that the residents' skin breakdown to a specified area and no evidence of treatment or assessment was found until 16 days after the initial documentation was carried out. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that supplies were readily available as required to treat pressure ulcers, skin tears or wounds and promote healing.

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

The Inspector carried out observation on an identified residents' skin breakdown dressing change on an identified date in November, 2016, with a Registered staff member and a direct care staff member. During the dressing changes the Registered staff member told the inspector that three areas of altered skin integrity did not have the prescribed treatment because the supplies were not available.

Interviews conducted with Registered staff members confirmed the directions from the ET nurse. The Registered staff members indicated they did not have the recommended dressing products to be used.

Interviews conducted with the home's WCC and DOC indicated it is the home's process is to ensure a skin and wound recommendations made by the ET nurse is followed and confirmed the staff did not have the products needed to carryout residents' dressings as per the ET recommendations.

The scope of the non-compliance is isolated.

The severity has negatively impacted the resident.

A review of the compliance history revealed the home had been issued non-compliances related to the Long-Term Care Homes Act, O. Reg r.50. (2)(b)(iii):
-Inspection 2015_393606_0011 carried out July 28, 2015, home was served a WN
-Inspection 2014_369153_0015 carried out October 20, 2014, home was served a VPC
[s. 50. (2) (c)]

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 instituted or otherwise put in place was complied with.

Home follows Medical Pharmacies polices. Policy "Medications for Injection-Safe Use of Medications Supplies in Ampoules", policy number 10-8, dated January 2014. In procedure number six it directs staff to: once the desired quantity is drawn into the syringe, the remaining quantity should be discarded using producer appropriate to the medication. (e.g. wasting of monitored medication requires a witness and appropriate documentation.) Do not save residual medication for subsequent injections unless explicitly directed by administrative staff and/or the manufacturer. The storage of opened ampoules with residual medication is not acceptable.

Medication storage observation was conducted in October, 2016 on an identified unit. During the medication observation the inspector observed an injectable medication sitting open in the medication cart. The medication was wrapped in a kleenex and stuffed into the middle of the tape roll and the opening of the medication was covered with a paper medication cup. The medication did not identify as to whom it was to be administered to, the Registered staff member indicated that it belonged to an identified resident.

An interview with a Registered staff member indicated he/she had opened the medication on an identified day in October, 2016, on an identified shift, and administered it as per physicians order. The Registered staff member went on to indicate that he/she would use the remaining medication to administer at a later time. The RPN confirmed the storage of the medication as observed by the inspector. The Registered staff member indicated he/she was unsure of the home's policy related to storing narcotic ampules and had no concern.

An interview with the DOC indicated that the Registered staff member did not follow the home's policy and indicated as the Registered staff member was new he/she was not educated on the home's medication policies. The DOC indicated the medication was not stored as per home's policy. [s. 8. (1) (b)]

2. Medication observation was conducted on an identified unit in October, 2016. The inspector observed on the "Individual Monitored Medication Record" for an identified resident that one tablet (tab) was borrowed and given to another resident.

Home follows Medical Pharmacies policies and procedures. Medical Pharmacies policy 3-6 "The Medication Pass", dated January 2014, under procedure 16 guides staff that: borrowing of one resident's medication for use by another is not permitted.

An interview with a Registered staff member on an identified unit indicated that medications are not to be borrowed between residents.

An interview with the above mentioned Registered staff member indicated it was he/she who borrowed one tab from one resident to give to another resident. The Registered staff member indicated that he/she was unaware that medications are not to be borrowed between residents.

An interview with the DOC stated that the home's expectation and policy is that staff not borrow medication from one resident to another and the Registered staff member mentioned above did not follow the home's policy related borrowing medication. [s. 8. (1) (b)]

3. Homes' policy "Skin and Wound Management Program - policy number: NPC E-30, dated September 2015, directs RN/RPN to: using a valid and reliable wound assessment tool, completes a skin assessment on admission, upon return of the resident from hospital, upon any return of the resident from an absence of greater than 24hours, quarterly and the RAI-MDS schedule and when there is a change in status.

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown through Minimum Data Set (MDS) previous to the most recent.

The Inspector carried out observation on an identified residents' skin breakdown dressing change in November, 2016, day shift with an identified Registered staff member and a direct care staff member. During the observation inspector observed multiple scratches to a specified area that were covered with a dressing.

The Inspector carried out a documentation review in November, 2016, on an identified residents' chart and no evidence of the scratches was found. Inspector was also unable to find a skin assessment for the scratches.

An interview with a Registered staff member indicated he/she was unaware of the scratches until he/she asked the direct care staff member to assist with turning the

identified resident. The Registered staff member indicated per the homes' policy any new skin issues or changes are to be document and a wound assessment is to be carried out, the Registered staff member further indicated that he/she did not get report or see any progress notes identifying the scratches.

An interview with a direct care staff member indicated he/she was providing morning care to the identified resident and informed the Registered staff member on an identified day in November, 2016, of the scratches.

An interview with RPN #209 confirmed he/she was informed of the six scratches and did observe the site on resident #009 but did not do anything further as to documenting or carrying out a skin assessment and did not follow homes' policy.

Interviews conducted with the homes' WCC and DOC indicated it is the homes' process is to ensure a skin and wound assessment is carried out to address any new skin and wound issues found on residents. The WCC and DOC confirmed residents' scratches on his/her trunk was not documented and no evidence of a skin assessment was found. The DOC indicated the Registered staff member did not follow the homes' skin and wound policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

Potential side rail restraint was triggered for an identified resident through resident

observation.
Observations indicated, quarter bed rail closest to the window was observed in the up position engaged and quarter bed rail closest to the door was observed in the up position vertical to the ceiling.

An interview with the identified resident confirmed he/she uses the quarter bed rail closest to the window for bed mobility to push him/herself up in bed and assist the resident at night for getting up to use the bathroom.

An interview with a direct care staff member indicated an identified resident has the quarter bed rail closest to the window engaged and uses the bed rail to push him/herself up in bed.

A review of residents' written plan of care dated August, 2016, indicated resident utilized one bedrail (Window side) engaged.

A review of residents' progress notes and physician orders did not show an order by a physician, RN, RPN, Occupational Therapists (OT), Physiotherapists (PT) or any other person for the use of the quarter bedrail as a Personal Assistive Services Device (PASD).

An interview with the DOC stated the home did not acquire an order for the above mentioned resident for the use of his/her quarter bed rail as a PASD. [s. 33. (4) 3.]

2. Potential side rail restraint was triggered for an identified resident through resident observation.

Observations indicated, quarter bed rail closest to the window was observed in the up position engaged and quarter bed rail closest to the door was observed in the up position vertical to the ceiling.

An interview with the above mentioned resident confirmed he/she uses the quarter bed rail closest to the window for bed mobility, get up out of bed and he/she can hold the bed rail when looking in his/her drawers near the window.

An interview with a direct care staff member indicated the resident has the quarter bed rail closest to the window engaged and uses the bed rail for residents own securities and it does not stop the resident from coming out of bed.

A review of residents' written plan of care dated July, 2016, indicated resident utilized one bedrail (Window side) engaged.

A review of residents' progress notes and physician orders did not show an order by a physician, RN, RPN, OT, PT or any other person for the use of the quarter bedrail as a PASD.

An interview with the DOC stated the home did not acquire an order for the resident for the use of his/her quarter bed rail as a PASD as the home did not identify the quarter bed rail closest to the window was a PASD. [s. 33. (4) 3.]

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 use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations., to be implemented voluntarily.

WN #5: 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.

Medication count observation was conducted on an identified unit in October, 2016. The inspector observed on the "Individual Monitored Medication Record" for an identified resident one tablet (tab) was borrowed and given to another resident.

A review of the residents' physician's orders dated June, 2016, indicated the medication was to be given twice per day and also as needed.

An interview with a Registered staff member indicated it was he/she who borrowed one tab from a resident to give to another resident in July, 2016. The Registered staff member stated that the resident was to receive two tabs as prescribed by the physician and indicated he/she only borrowed one tab from the resident and only administered one tab to the resident for his/her next dose. The Registered staff member identified he/she did not follow the physicians prescribed order for the resident in receiving two tabs.

An interview with the DOC stated the above mentioned resident #009 did not receive his/her prescribed dose of medication and the Registered staff member did not follow the prescribed order. [s. 131. (2)]

2. The Ministry of Health (MOH) received an email from a family member of a resident in October, 2014. The email indicated resident did not receive medication that was prescribed by the physician on three different occasions since the resident had been admitted to the long-term care home.

A review of residents' PCC progress notes indicated four medication incidents had occurred where the prescribed medication was not administered to resident as ordered by the physician:

1) November, 2013: Medication ordered in November 2013. The Medication Administration Record System (MARS) indicated the medication was not administered on four identified dates.

2) September, 2014: The Medication Administration Record System (MARS) indicated the medication was not administered on one identified date.

3) PCC notes: February, 2015: Resident was administered another residents medication by mistake.

4) June, 2016: Medication was not administered to the resident on one occasion.

An interview with the DOC indicated the above four medication incidents did occur involving an identified resident and the home carried out "Medication Incident Reports", contacted the home's physician, Medical Pharmacy, and residents' Substitute Decision Maker (SDM) in each incident to ensure that proper process was followed. The DOC indicated the above mentioned resident had no ill effects from the medication incidents and the staff involved were counseled along with providing education to the nurses involved. The DOC confirmed the nurses did not follow and administer the prescribed medication to the resident as ordered by the physician. [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 where administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

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

Medication observation was conducted on an identified date in October, 2016, on an identified unit with a Registered staff member.

The inspector observed the Registered staff member did not carry out hand hygiene between resident medication administration for three residents' medications. Aloemed hand sanitizer was observed to be located on the left side of the medication cart by the inspector.

An interview with the Registered staff member indicated it was the home's expectation that he/she carries out hand hygiene between residents during medication administration. The Registered staff member confirmed he/she has hand sanitizer on the medication cart and confirmed he/she did not perform hand hygiene between medication administrations.

An interview with the DOC stated it was the home's expectation staff perform hand hygiene between residents during medication administration as and it was best practice and the Registered staff member did not follow best practice for infection control. [s. 229. (4)]

Additional Required Actions:

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

WN #7: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Medication observation was conducted on an identified day in October, 2016, on an identified unit with a Registered staff member. The Registered staff member was administering an injection. An identified resident was sitting in his/her room at the foot of his/her bed. The resident consented to have the injection. The Registered staff member lifted residents top up and residents beige undergarment was visible to the inspector. The inspector also observed the resident's privacy curtain and room door was open and resident was visible to passersby.

An interview with the Registered staff member indicated it was the home's expectation to provide residents with privacy when administering any injectable medication. The Registered staff member confirmed he/she administered the residents' injectable medication and did not close the room door and did not provide privacy to the resident during care.

An interview with the DOC indicated the home's policy "Resident Privacy and Intimacy" policy NPC F-95, indicated that staff are to close doors, draw privacy curtains and close blinds prior to any procedure. The DOC confirmed that RPN should have provided privacy during insulin administration for the resident. [s. 3. (1) 8.]

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 to involve staff and others 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 complement each other.

The RAI-MDS assessment of January, 2016, indicated that the resident had a change in urinary status and had now been assessed as requiring an external appliance.

A record review for an identified resident indicated that resident had been transferred to hospital and had returned with the external appliance.

Interviews with a Registered staff member, indicated that the rationale for the external appliance was unknown. The Registered staff member revealed that there had never been a follow up report received from the specialist. The Registered staff member further indicated that there has been no follow up by the home with the specialist to discuss the reason for the external appliance, or any treatment plan or goals.

An interview with the DOC indicated that the expectation of the home is to have followed up with the specialist to receive a report from the appointment.

The DOC further confirmed that there had not been care collaboration between the homes' staff and the specialist in the assessment of the resident so that their

assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provisions of the care set out in the plan of care are followed.

The Ministry of Health and Long Term Care Action Line had been contacted by a complainant on an identified day in August, 2015, indicating that a resident had been diagnosed with an infection, and over the course of this past year had gotten progressively worse. The complainant further indicated that he/she feels that the resident had been neglected which resulted in the resident's death.

A review of the resident's clinical records revealed that the identified resident had a treatment order to complete twice per day. It had been identified through clinical review that there had been missing documentation on the treatment administration records 24 times between June 2014 and January 2015.

Registered staff indicated during an interview that when a treatment is completed the registered staff are expected to sign the treatment administration record to indicate that the skin treatment had been completed as per the directions by the prescriber. The Registered staff further indicated that the above mentioned missing treatments indicated the care had not been provided and would have met the definition of neglect mentioned above.

An interview with the Director of Care indicated that every employee receives education upon hire and annually thereafter relating to abuse and neglect. The Director of Care further confirmed that there had been a failure to provide the above mentioned resident with a treatment on 24 occasions between June 2014 and January 2015 as listed above and therefore met the definition of neglect. [s. 6. (9) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received 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 circumstance of the resident require, and assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

This IP had been initiated relating to a triggered item for continence during the RQI. A review of an identified residents' RAI-MDS assessment records revealed that the resident had been assessed as occasionally incontinent of urine on admission, the RAI-MDS assessment of a specified date, indicated that the resident had a change in urinary status and had now been assessed as requiring an external appliance.

A review of the home's Continence Care and Bowel Management, policy, #NPC E-05, dated June 2013, directed registered nursing staff to "collaborate with resident/substitute decision maker and family and interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument on admission and/or after any change in condition that may affect bowel or bladder continence".

Record review of an identified resident indicated that resident did not have a bladder and bowel continence assessment that includes identification of causal factors, patterns, types of incontinence, medications and potential to restore function when the continence status changed from occasionally incontinent to requiring an external appliance.

Record review of an identified resident indicated that resident did not have a bladder and bowel continence assessment that includes identification of causal factors, patterns,

types of incontinence, medications and potential to restore function on admission or when the continence status changed from continent to frequently incontinent.

Interviews with Registered staff indicated that residents are assessed for incontinence on admission, or with any change in health status, using the computerized bladder and bowel continence assessment located in PCC. The registered staff indicated that this form is used for the identification of causal factors, patterns and types of incontinence, and medications. The above mentioned Registered staff further indicated that the two identified residents should have been assessed using the bowel and bladder continence assessment tool when their continence status changed.

An interview with the DOC indicated that the expectation of the home is to have residents assessed using the bowel and bladder continence assessment tool for all admissions and change of status.

The DOC further confirmed that a bowel and bladder continence assessment had not been completed for residents' change of continence status or residents' admission or change of continence status. [s. 51. (2) (a)]

WN #10: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)

Medication observation was conducted on an identified unit in October, 2016. The inspector observed on the "Individual Monitored Medication Record" for an identified resident one tablet (tab) was borrowed and given to another resident.

A review of residents' physician's orders dated June, 2016, indicated a medication had been ordered to be given two tabs twice daily and as needed.

An interview with a Registered staff member indicated it was he/she who borrowed one tab of the medication from one resident to give it to another resident. The Registered staff member stated that resident was to receive two tabs of medication as prescribed by the physician and indicated he/she only borrowed one tab from the other resident and only administered one tab to the identified resident for his/her later dose. The Registered staff member identified this incident as a medication error and stated it is the home's policy that then a medication error is identified, the RN, DOC, physician, and the family is informed and a medication error form is to be completed. The Registered staff member stated he/she did not see this as a medication error until it was identified by the DOC a couple of days ago and stated he/she did not complete a medication error form.

An interview with the DOC stated the above mentioned resident did not receive his/her prescribed dose of medication and identified this to be a medication incident. The DOC further indicated a medication incident form was not completed with the pharmacy for the identified incident above. [s. 135. (2)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2016_491647_0009
Log No. / Registre no:	030275-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 21, 2017
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	GEORGIAN MANOR HOME FOR THE AGED 7 HARRIET STREET, PENETANGUISHENE, ON, L9M-1K8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Sheridan

To CORPORATION OF THE COUNTY OF SIMCOE, 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. 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).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. develop a system or process to ensure all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff
2. provide re-education and training to all staff in the home related to 1
3. The licensee shall develop, implement and submit a plan, that includes all the above two requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to jennifer.brown6@ontario.ca by March 6, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that all residents were protected from neglect by the licensee or staff.

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

Documentation review of an identified residents' progress notes and wound assessments identified six areas of alteration in skin integrity over several identified months in 2016.

The following concerns were noted during progress note review for the time period of November, 2015 – October, 2016:

1) Progress note dated August, 2016, indicated the identified resident had a

specified alteration to skin integrity. A review of the wound assessment tool V1, Treatment Administration Record (TAR) and progress notes did not indicate care being provided for the above mentioned area until 16 days later. At the time of the inspection the area of skin breakdown had progressed.

2) A review of the wound assessment tool carried out in October, 2016, indicated skin breakdown to another specified area. No progress notes or skin assessment were found identifying skin break down to this area.

The inspector carried out an observation on the above mentioned residents' dressing change in November, 2016, with a Registered staff member and a direct care staff member. During the dressing change it was observed that the treatments were not administered as prescribed by the ET nurse for five of the wounds.

The inspector observed multiple scratch marks on a specified area on the resident with a dressing dated in November, 2016. The Registered staff member indicated when the site was exposed he/she was unaware of the scratches as he/she did not get report on the site or see a Point Click Care (PCC) note or skin assessment on the site. The direct care staff member indicated he/she had initially seen the site in November, 2016, when he/she was providing care and had reported it to the Registered staff member that morning.

A review of the PCC note and skin assessments did not identify the multiple large scratch marks on the resident as the inspector did not find documentation on PCC for the site until an identified date in November, 2016.

An interview with a Registered staff member indicated he/she worked on an identified date in November, 2016, on an identified unit and carried out the residents' dressings on that day. The Registered staff member indicated that he/she did not have the required supplies for three of the dressings and for two of the dressings, the nurse believed that he/she had administered the treatment properly.

An interview with the home's Wound/Skin Care Coordinator (WCC) verified the skin breakdown to the lower extremity was not assessed on admission and was assessed five days later. The skin breakdown to the trunk was identified in October, 2016, when it had deteriorated and no prior progress notes or skin assessments was carried out, the second skin breakdown to the trunk was

identified in August, 2016, in a progress note when the site had a blister at the time of the inspection, and now the site had worsened. The WCC indicated the staff did not follow the homes skin and wound care policy for the above sites and the identified residents' ulcers had gotten worse. When the WCC was informed of the findings of the observations carried out of the above mentioned residents' ulcers the WCC indicated that the home did not follow the ET nurses orders and did not provide the proper care to the resident. When the WCC was informed of the multiple scratches on the trunk of the resident, the WCC indicated staff are expected to carry out a skin assessment when a new skin issue is identified and verified there was no evidence of a progress note or skin assessment being carried out for the site. The WCC in closing indicated the home did not address residents' skin issues.

During an interview with the DOC the inspector informed him/her of the dressing observations as indicated above. The DOC indicated the direct care staff are to inform the Registered staff members immediately of any skin issue and a skin assessment is to be carried out. The DOC confirmed the staff in the home did poor documentation and an assessment was not done and did not follow the homes expectation related to carrying out skin assessment for the resident. When the DOC was informed of the findings of the multiple scratches on an identified area, the DOC indicated staff are expected to document the changes in the skin and home's policy was not followed. In closing the DOC identified the dressing changes and dressings carried out by the staff and staff did not follow dressing orders by the ET nurse, assessment of the resident was not carried out post admission until five days later, the skin breakdown was discovered at a stage of deterioration with no previous assessment carried out, an identified area was assessed 16 days later, was now documented as deteriorated. The DOC identified the above concerns as neglect of the above mentioned resident.

The scope of the non-compliance is isolated.

The severity has negatively impacted the resident.

A review of the compliance history revealed the home had been issued non-compliances with voluntary plans of correction (VPC's) related to the Long-Term Care Homes Act, O. Reg c.8, s. (19)1:
-Inspection 2014_369153_00098 carried out August 17, 2014, home was served a VPC
-Inspection 2014_297558_0018 carried out November 6, 2014, home was

served a VPC [s. 19. (1)] (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

Upon receipt of this order the licensee shall:

1. develop a system or process to ensure all residents receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required
2. develop a system or process to ensure all equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing
3. provide re-education and training to all staff in the home related to 1 and 2 above
4. The licensee shall develop, implement and submit a plan, that includes all the above three requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to jennifer.brown6@ontario.ca by March 6, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

A review of an identified residents' PCC progress notes from August, 2016, indicated multiple skin breakdown on trunk. After the initial identification there were no progress notes or skin assessment found with treatments being provided to the skin issues indicated above.

A review of the progress notes carried out in September, 2016, was the first time the skin breakdown had been addressed.

Interviews conducted with the home's WCC and DOC indicated it is the home's process is to ensure a skin and wound assessment is carried out to address any new skin and wound issues found on residents. The WCC and DOC confirmed that the residents' skin breakdown to a specified area and no evidence of treatment or assessment was found until 16 days after the initial documentation

was carried out. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that supplies were readily available as required to treat pressure ulcers, skin tears or wounds and promote healing.

An identified resident was triggered for skin breakdown through staff interview and census record review and for worsening skin breakdown Minimum Data Set (MDS) previous to the most recent.

The Inspector carried out observation on an identified residents' skin breakdown dressing change on an identified date in November, 2016, with a Registered staff member and a direct care staff member. During the dressing changes the Registered staff member told the inspector that three areas of altered skin integrity did not have the prescribed treatment because the supplies were not available.

Interviews conducted with Registered staff members confirmed the directions from the ET nurse. The Registered staff members indicated they did not have the recommended dressing products to be used.

Interviews conducted with the home's WCC and DOC indicated it is the home's process is to ensure a skin and wound recommendations made by the ET nurse is followed and confirmed the staff did not have the products needed to carryout residents' dressings as per the ET recommendations.

The scope of the non-compliance is isolated.

The severity has negatively impacted the resident.

A review of the compliance history revealed the home had been issued non-compliances related to the Long-Term Care Homes Act, O. Reg r. 50. (2)(b)(iii):
-Inspection 2015_393606_0011 carried out July 28, 2015, home was served a WN
-Inspection 2014_369153_0015 carried out October 20, 2014, home was served a VPC [s. 50. (2) (c)] (604)

2. The licensee has failed to ensure that supplies were readily available as required to treat pressure ulcers, skin tears or wounds and promote healing.

Resident #009 was triggered for stage III/IV pressure ulcer through staff interview and census record review and for worsening pressure ulcer through Minimum Data Set (MDS) previous to the most recent.

The Inspector carried out observation on resident #009's pressure ulcer dressing change on November 8, 2016, day shift with RPN #202 and PSW #117. During the pressure ulcer, dressing changes the following was revealed:

- Right Heel Dressing
Dressing Order: Acetic Acid 0.5% soak x 10 min apply alginate Ag and cover with dry dressing
-Removed dressing: Kling, 4x4 soaked with betadine as per RPN #202
-New Dressing: RPN #202 cleansed right heel with N/A and started to paint with betadine and RN #210 entered and told the RPN #202 it was the wrong dressing. RPN #202 then read the dressing order and cleaned site with N/S and applied alginate Ag and covered with dry dressing and applied cling to keep dressing in place
Concern: No Acetic Acid used to soak used as per ET order and RPN #202 indicated no acetic acid was available

- Ischiam (Left side lower buttock)
Dressing order: Left ischam to cleanse and irrigate with N/S and irrigation tip catheter and pat dry. Pack with betadine soaked 1 AMD ribbon gauze. Cover with 4x4 and mefix
Removed dressing: No dressing as PSW indicated resident had a BM and dressing was dirty.
New dressing: Irrigated with a syringe tip, betadine soaked 4x4 and mefix to hold.
Concern: 1"AMD ribbon gauze not used RPN #202 indicated no ribbon gauze was available

-Right Hip
Dressing order: Acetic Acid 0.5% soak x 10 min apply detained soaked gauze to necrotic area, cover with 4x4 and mefix.
Removed dressing: ABD pad with mefix
New dressing: Cleansed with N/S, 4x4 soaked with betadine, ABD pad with mefix to hold
Concerns: No acetic acid used to soak area for 10 min as RPN #202 indicated

no acetic acid was not available.

Interviews conducted with RPN #202 and #209 confirmed the ET nurse recommended acetic acid 0.5% to be used to for the right trochanter and right heel and the two sites are to be soaked for 10 minutes and 1centimeter (cm) ribbon gauze to be used to pack the ischial pressure ulcer. Both RPN's indicated they did not have the recommended dressing products to be used for resident #009's dressing changes.

Interviews conducted with the home's WCC and DOC indicated it is the home's process is to ensure a skin and wound recommendations made by the ET nurse is followed and confirmed the staff did not have the products needed to carryout resident #009's dressings as per the ET recommendations.

The scope of the non-compliance is isolated.

The severity has negatively impacted the resident.

A review of the compliance history revealed the home had been issued non-compliances related to the Long-Term Care Homes Act, O. Reg r. 50. (2)(b)(iii):
-Inspection 2015_393606_0011 carried out July 28, 2015, home was served a WN
-Inspection 2014_369153_0015 carried out October 20, 2014, home was served a VPC (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 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 21st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

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