Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2016	2015_267528_0026 (A1)	034263-15	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

HARDY TERRACE
612 Mount Pleasant Road R. R. #2 BRANTFORD ON N3T 5L5

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 2015

This inspection was done concurrently with Complaint Inspection Log #'s: 004860-15, 011831-15, and 029326-15 related to responsive behaviours and resident injury during transport

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Food Services Supervisor (FSS), Registered Dietitian (RD), Physiotherapist(PT), Bookkeeper, Clinical Resource Nurse, Resident Assessment Instrument (RAI) Coordinator, Recreation Supervisor, registered nurses (RNs), registered practical nurses (RPNs), personal support workers(PSWs), maintenance worker, housekeeping staff, laundry staff, dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **17 WN(s)**
- **2 VPC(s)**
- **3 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A. In May 2015, resident #020 sustained an injury while being transported by staff. According to the progress notes the assistive device had been broken for approximately two months. Review of the investigation notes of the incident indicated that the resident was not in a safe position when transported by PSW #127 and which resulted in an injury.
Interview with registered staff #122 confirmed that the resident was not in a in safe position when being transported which resulted in an injury.

Interview with the DRC and review of the progress notes revealed that after the injury the resident was unsafely transported by staff for an additional eleven days. The DOC confirmed that PSW #127 did not ensure the resident was safely positioned prior to transporting the resident and, as a result, sustained an injury.

B.In May 2015, the Physiotherapist reassessed resident #020's transfers and identified they required the sit and stand lift and hoyer lift at different times of the day, and the transfer logo was changed in their room.

Approximately two weeks later, the registered staff documented pain and swelling to the residents lower extremity; however, the resident was transferred back to bed with the sit and stand lift. Registered staff #113 confirmed that a hoyer lift should have been used as outlined in the resident's plan of care.

The in the next few day, registered staff documented the resident had severe pain when weight bearing, and difficult to transfer; however, the sit to stand lift was used for two days until the resident was changed to a full mechanical lift at all times.

At the end of May 2015, the resident was diagnosed with injuries. The DRC confirmed that the resident was not safely positioned before being transported and that staff continued to use the sit to stand lift despite ongoing complaints of severe pain and change in ability to weight bear.

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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs was monitored and documented.

1. In May 2015, resident #020 sustained an injury and was sent to hospital for treatment. The resident returned the following morning complaining pain. Eleven days later the resident was diagnosed with injuries. Despite ongoing complaints of pain, registered staff failed to monitor and document the effectiveness of pain medications sixteen times

A. During the days following the injury, the resident continued to express ongoing pain. Review of the narcotic medication records, pain flow records, electronic medication administration record (eMAR) notes; which revealed that registered staff did not monitor and document the effectiveness of the pain medications provided to the resident after pain was reported sixteen times.

Interview with the DOC on December 17, 2015, confirmed that staff did not monitor and document the effectiveness of medications, as listed above, when they were administered for complaints of pain made by resident #020.

B. The Policy for "Pain Management, NM-II-P010", effective from February 2009 to December 2015 directed registered staff to assess the residents' pain using the Pain Flow Record and Pain Assessment Tool and evaluate the resident's responses to the as needed pain (PRN) medication and document; and to notify the physican if the resident consistently reports moderate to horrible or excruciating pain for 24 to 48 hours and PRN medications are given more than three times a day.
i. Registered staff documented resident #020 as having ongoing moderate to severe pain following an injury on the pain flow record and progress notes; however, the physician was not notified of ongoing pain until seven days after a change in pain medication orders.
ii. More than three doses of PRN medications were administered to the resident five out of ten days following the injury; however, the physician was not notified until the tenth day.
iii. Review of the eMAR notes and Pain Flow Record identified that registered staff did not consistently document the resident's pain using the Pain Assessment Tool. Interview with DOC on December 17, 2015 confirmed that the pain flow record was not completed although as need analgesia was being administered for pain. Additionally, staff did not document the resident's pain using the Pain Flow Record and Pain Assessment Tool for each administration of analgesia, as required.

2. The plan of care for resident #64 identified that the resident had chronic pain related to a diagnosis of multiple chronic diseases. Interventions included but were not limited to administration of an opioid analgesia as needed, and to document the effectiveness. In December 2015, the eMARS identified that the resident received the opioid analgesia daily, approximately forty-six doses. Review of the progress notes and Pain Flow Record revealed that the resident's pain was not reassessed following administration of the opioid analgesia for pain, approximately thirty-five out of forty-six times. Interview with the DOC confirmed that registered staff should be documenting effectiveness of as needed medication administration, as outlined in the policy. (528) [s. 134. (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 failed to ensure that resident #020 was free from neglect by the licensee or staff in the home as defined in O.Reg. 79/10, s.5, where 'neglect' means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In May 2015, resident #020 sustained an injury while being transported by staff. The resident was sent to hospital for treatment. Review of the clinical health record indicated that the resident's assistive device had been broken for approximately two months, and continued to be broken an additional eleven days after the injury.

After returning to the home, the resident complained of moderate to severe pain with a change in weight bearing status. The staff continued to assist resident with transfers using a sit to stand lift for four days following the injury, and then was changed to a full mechanical lift. The nursing team assessed a change in the area, which was not reported to the physician and no new interventions were put in place.

Eleven days after the injury the resident was diagnosed with multiple fractures.

Interview with the DRC and PT confirmed that the resident was using an assistance device that was unsafe for two months prior to the injury and an additional eleven days following the injury. It was also confirmed that the resident complained of ongoing moderate to severe pain with weight bearing, and the sit to stand lift continued to be used. It was also confirmed that the physician was not notified of ongoing complaints of moderate to severe pain, change in weight bearing status and assessment of the area of injury, until eleven days after the injury.

It was confirmed by the DRC that the home failed to provide resident #020 with the treatment, care and assistance they required for health, safety or well being and was neglected by the home. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

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

In May 2015, the PT assessed resident #020 to require the full mechanical lift for transfers on the evening shift. Review of the written plan of care and Kardex indicated that the resident was a full mechanical lift for all transfers. Registered staff #110 indicated there was no clear direction related to which mechanical transfer the staff were to use on day shift. [s. 6. (1) (c)]

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

In September 2015, resident #007 was admitted with an indwelling catheter. Registered staff and PSW staff documented catheter placement and care. Review of the Minimum Data Set (MDS) Assessment from September 2015, did not code the resident as having an indwelling catheter. Interview with RAI Coordinator confirmed that the coding was not consistent with the registered staff admission assessment related to the resident's indwelling catheter. (528) [s. 6. (4) (a)]

3. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A. In November 2015, resident #001 sustained a fall with no injury. Review of the Post Fall Investigation and the progress notes revealed that an intervention was not in place at the time of the incident. Review of the written plan of care indicated that staff was to ensure the intervention was applied when the resident was in bed for safety and falls prevention. Interview with registered staff #116 confirmed the intervention was not in place and that staff did not provide care as directed in their plan of care.

B. The written plan of care for resident #002 identified that the resident was at risk for falls. Interventions included, but were not limited to, two half bed rails raised when in bed, bed and chair alarm, fall out mat on floor. The resident was observed on December 14, 2015 at 1400 hours in bed without falls mat in place. Confirmed with PSW #105 that the falls mat was not on floor as outlined in the plan of care.

C. On December 9 and 11, 2015, resident #009 was observed in bed with two half assist rails raised in the transfer position. Review of the bed rail assessment completed in December 2015, revealed that bed rails were not indicated at this time. Review of the written plan of care and Kardex did not indicate the resident used bed rails. The resident stated during an interview they did not use bed rails nor did they want them raised on their bed. Interview with registered staff confirmed that the bed rails should not of been raised as they did not need or use bed rails and that staff did not provide care as directed in their plan of care.

D. On December 10 and 11, 2015, resident #011 was observed in bed with one half assist rail raised in the transfer position on the left and one half assist rail raised in the

guard position on the right. Review of the bed rail assessment completed in October 2015, revealed that one half bed rail was to be raised. Review of the written plan of care and Kardex indicated that the resident required one half bed rail as a PASD. Interview with PSW's stated the resident was to have only one half bed rail raised when in bed. Registered staff #113 confirmed that the resident only required one bed rail raised and staff did not provide care as directed in their plan of care.

E. Review of the plan of care for resident #020 indicated that the PT changed the transfer from wheelchair to bed to a full mechanical lift in May 2015 and that a logo was put in their room. Review of the progress notes in May 2015, indicated that the resident was transferred back to bed before dinner with the sit and stand lift. Registered staff #113 confirmed that the resident was a hoyer lift and that staff did not provide care as directed in their plan of care. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A. Review of the Physiotherapy quarterly assessment completed in December 2014, stated resident #020 was discharged from the program and the care plan was updated. Review of the written plan of care indicated they were on an active physiotherapy program. Interview with the Physiotherapist in December 2015, stated that the resident was no longer on an active physiotherapy program and confirmed that the care set out in the plan was no longer necessary.

B. Resident #060's plan of care stated they were able to release their lap belt. On December 9 and 22, 2015, the resident was observed being unable to release the lap belt. PSW #100 and #126 reported the resident was unable to release the belt. RPN #110 confirmed the resident could not release the belt and the care plan was not updated when their care needs changed. (585)

C. In May 2015, resident #020 sustained multiple injury and sent to the hospital for treatment . Review of the written plan of care did not include that the resident had sustained any injuries nor did it include pain related to the injury. The DOC confirmed that the written plan of care was not reviewed and revised when they sustained multiple injuries. [s. 6. (10) (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 the following:
i. that the plan of care sets out clear directions to staff and others who provide direct care to the resident
ii. that the care set out in the plan is provided to the resident as specified in the plan
iii. the resident is reassessed and the plan of care reviewed and revised at least every six months or when the resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

A. On December 9, 2015, resident #060 was observed sitting in a wheelchair with a front-fastening lap belt applied, with a space of four finger widths noted between the belt and their torso. PSW #126 reported the resident was unable to release the belt and they were unsure how it was to be applied. RPN # 101 reported the belt was to be applied two finger widths from the resident's torso.

B. On December 22, 2015, resident #060 was observed sitting in a wheelchair, with a front-fastening lap belt applied, with a space of four finger widths noted between the belt and their torso. PSW #100 reported the resident was unable to release the belt and that the home's expectation was for the belt be applied with a space no more than two finger widths; however, the resident's belt often became loose. RPN #110 confirmed the belt was used as a restraint and not applied in accordance to manufacturer's specifications (the belt be applied with a space no more than two finger widths). (585) [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On December 9, 2015, during an initial tour of the home, the shower room on home area "A" was observed to have brown and orange scaling on the tiles at the base of the wall . Interview with Maintenance Staff confirmed that the scale was related to hard water and the home periodically sought out external contractors for additional cleaning; however no longer had a contract with any services at this time. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

On December 9, 2015, it was observed that the home did not have a resident-staff communication and response system located in four outdoor areas: the general unit courtyard, special unit court yard, small courtyard off the special unit dining room and the porch accessible through the cafe. The Administrator confirmed that a communication and response system was not available in the identified areas, which were accessible to residents. [s. 17. (1) (e)]

WN #8: 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 failed to ensure that the use of a Personal Assistance Services Device (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 were satisfied:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A. On December 16 and 17, 2015, resident #020 was observed sitting in their tilt wheelchair. Review of the written plan of care directed staff to reposition the resident as needed in the tilt wheelchair to ensure they were comfortable and to tilt the wheelchair for manoeuvering. Interview with PSW #125 stated that the resident was tilted while being transported on the unit. Review of the clinical record indicated there was no documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. Registered staff # 113 confirmed that the tilt wheelchair was not assessed as a PASD, nor did they have documented consent or approval for its use. [s. 33. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A. In October 2015, resident #041 demonstrated responsive behaviours and was subsequently transferred to hospital. Upon return to the home, interventions were implemented to monitor and document the resident's location and behaviours using the resident observation record (ROR) form. Review of the ROR form revealed nine occasions of incomplete documentation during the observation period. Registered staff #113 reported staff were to document every 30 minutes and was unable to confirm if the resident was monitored; however, confirmed documentation was incomplete.

B. In November 2015, the home implemented an intervention to monitor the resident's responsive beahviorus every 30 minutes using Dementia Observation System (DOS) charting. Review of the DOS charting revealed 33 occasions of incomplete documentation in November 2015 and 65 occasions in December 2015. Registered staff #113 reported staff were to document every 30 minutes and was unable to confirm if the resident was monitored; however, confirmed documentation was incomplete. [s. 53. (4) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond to Residents' Council in writing within 10 days of receiving concerns or recommendations under either paragraph 6 or 8 of subsection (1).

A. A review of Residents' Council records revealed that the home did not provide a written response to council within 10 days of receiving concerns and recommendations in September and October 2015, which was confirmed by the Administrator.

B. One council member reported that in May 2015, a recommendation was brought forth to acquire a pool table; however no response was provided. The recreation supervisor and Administrator confirmed that no written response was provided to council regarding the recommendation. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the food production system, at a minimum, provided preparation of all menu items according to the planned menu.

A. On December 9, 2015, puree salmon sandwich was on the planned menu for lunch. During a dining observation, the sandwich appeared runny, pooling out on plates when served. Dietary staff #104 confirmed the item did not look appropriate as it was runny and did not hold its shape.

B. On December 11, 2015, puree yogurt granola parfait with seasonal fruit was on the planned menu for lunch. During a dining observation, the puree fruit, including honey dew, cantaloupe and banana appeared runny, pooling on plates. The food services supervisor reported the home's recipes for puree foods indicated they were to be prepared to a pudding thick consistency, and the items were not prepared according to the planned menu. [s. 72. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily breakfast menu was communicated to residents.

On December 9, 2015 and December 11, 2015, during meal observations, no daily breakfast menu was observed. The food services supervisor confirmed the home did not post daily breakfast menus. [s. 73. (1) 1.]

2. The licensee failed to ensure that there were appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs, tables at an appropriate height to meet the needs of all residents.

A. On December 9, 2015, during lunch, resident #040 was observed out of the dining room in an adjacent common area, sitting on a sofa chair, eating at an over bed table. The resident stated they wanted to sit in the dining room at a table. The food services supervisor reported the resident sat alone due to previously assessed care requirements, however confirmed the resident was not provided appropriate furnishings, including a dining room chair and table.

B. On December 9 and 11, 2015, during lunch, resident #001 was observed sitting low, with their collarbone at the same height to the table. The dietary services supervisor confirmed the resident was not provided comfortable dining room seating and table height to optimally meet the needs of the resident. (585) [s. 73. (1) 11.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of Residents' Council in the development and carrying out of the satisfaction survey.

Residents' Council co-chairs reported council was not involved in the development and carrying out of the satisfaction survey. The Administrator confirmed the licensee had not sought advice from the council since 2010 regarding the development and carrying out of the survey. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the course of the inspection, lingering odours were noted in home. On December 10, 11, 14 2015, incontinent odours were noted in shared resident bathrooms. Interview with housekeeping staff #117 identified a variety of interventions to combat odours including but not limited to, increasing the frequency of areas with odours, air fresheners, room deodorizers, and notifying maintenance and housekeeping supervisors. In an interview with the Housekeeping Supervisor and a review of the homes housekeeping procedures, it was identified that procedures included routine daily cleaning, additional deep room and floor cleaning on alternating six to eight week schedules; but, procdures did not include a procedure for dealing with lingering offensive odours. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

A. On April 9, 2014, a memo was sent to laundry staff related to a new form for Missing Clothing which directed laundry staff that if an item was identified as missing to start the form and that each shift they should be searching for the missing item and documenting at the end of the shift and if the item was found it would be documented at the bottom. On April 15, 2014, a memo was sent to nursing department directing nursing staff if any clothing items are missing to let laundry know immediately.

i. Resident #007 and resident #009 were interviewed and stated they had reported missing laundry items to registered staff and personal support workers. A review of the progress notes for resident #009 verified the registered staff had documented missing clothing. Interview with PSW #119 stated that they were aware of the missing clothing items for resident #007 and reported this to registered staff. Review of the 24 hour report binder and laundry binder did not include a Missing Article or Missing Laundry form completed for the two residents. Interview with laundry staff #120 confirmed that the Missing Laundry form was not completed for the two residents. Interview with registered staff #113 confirmed they had not completed the Missing Article Form for the identified residents and they had not followed the process to report and locate lost clothing items. [s. 89. (1) (a) (iv)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

On December 9, 10, 11 and 14, 2015 assist rails on resident #004, #011's and #041's beds were found loose. PSW #107 reported when rails were found in poor repair, staff were to log a maintenance request in the home's daily maintenance log. Review of the log did not reveal any documentation for maintenance requests to fix the rails. Maintenance staff #108 and #109 confirmed that the rails were loose and they were unaware the assist rails were in poor repair. (585) [s. 90. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow –up action required.

The home's policy, "ADM-VII-035, Complaints, Residents and Families" dated, September 2014, indicated that each verbal or written complaint that could not be resolved within 24 hours was followed up by immediately investigating the complaint and resolved if possible and a response provided within ten business days. If the complaint was not resolved, the complaint was acknowledged and a response provided as soon as possible.

Resident #009 reported they were missing money approximately eight months ago. Review of the progress notes in March 2015 revealed that the resident reported to registered staff that they were missing money from their room. Review of the 2015, Complaints did not include documentation related to the resident's complaint about their missing money. Interview with PSW #115 stated they were aware of the missing money and instructed the resident not to keep money in their room and to give their money to the book keeper to be locked up. Registered staff #113 and the Administrator stated that they were unaware of the missing money and that a complaint form was not completed as per the home's policy and therefore there was no follow-up to this complaint. [s. 101. (2)]

2. The licensee failed to ensure that the documented complaints record was reviewed and analyzed for trends at least quarterly.

The plan of care for resident #20 identified that in May 2015, the family of the resident #20 expressed care concerns. Review of the 2015 Complaints Log, did not include the concerns; however, the Administrator had a separate documented record that included all items required in Subsection (2). The Professional Advisory Committee (PAC) Quarterly Meeting Minutes from June and September, 2015 documented zero complaints for both quarters. The Administrator stated that complaints were analyzed quarterly at PAC Meeting. Since the complaint from May 27, 2015 was not identified in the June and September 2015 PAC Meetings, all documented complaints were not reviewed and analyzed at least quarterly. (528) [s. 101. (3) (a)]

Issued on this 1st day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_267528_0026
Log No. / Registre no:	034263-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 26, 2016
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	HARDY TERRACE 612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAUL ROOYAKKERS

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning techniques with all residents as identified in their written plan of care prior to transporting the resident including:
i. Provide education to all direct care staff on safe transferring and positioning techniques for all residents related to proper positioning of residents' feet on foot pedals before transporting them.
ii. Ensure that all staff are following the plan of care especially in relation to transferring the resident with the sit to stand lift or the hoyer lift and are using the correct mechanical lift that the resident was assessed to use.

Grounds / Motifs :

1. 1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A. In May 2015, resident #020 sustained an injury while being transported by staff. According to the progress notes the assistive device has been broken for approximately two months. Review of the investigation notes of the incident indicated that the resident was not in a safe position when transported by PSW #127 and which resulted in an injury.

Interview with registered staff #122 confirmed that the resident was not in a safe position when being transported which resulted in an injury.

Interview with the DRC and review of the progress notes revealed that after the injury the resident was unsafely transported by staff for an additional eleven days. The DOC confirmed that PSW #127 did not ensure the resident was safely positioned prior to transporting the resident and, as a result, sustained an injury.

B.In May 2015, the Physiotherapist reassessed resident #020's transfers and identified they required the sit and stand lift and hoyer lift at different times of the day, and the transfer logo was changed in their room.

Approximately two weeks later, the registered staff documented pain and swelling to the residents lower extremity; however, the resident was transferred back to bed with the sit and stand lift. Registered staff #113 confirmed that a hoyer lift should have been used as outlined in the resident's plan of care.

The in the next few day, registered staff documented the resident had severe pain when weight bearing, and difficult to transfer; however, the sit to stand lift was used for two days until the resident was changed to a full mechanical lift at all times.

At the end of May 2015, the resident was diagnosed with injuries. The DRC confirmed that the resident was not safely positioned before being transported and that staff continued to use the sit to stand lift despite ongoing complaints of severe pain and change in ability to weight bear. (581)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

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. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that all residents, including but not limited to residents #020 and #064, who are receiving analgesia for pain are monitored, that documentation includes the resident's response and the effectiveness of the drugs, and if the drug is ineffective appropriate actions are taken as necessary.

Grounds / Motifs :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs was monitored and documented.

In May 2015, resident #020 sustained an injury and was sent to hospital for treatment. The resident returned the following morning complaining pain. Eleven days later the resident was diagnosed with injuries. Despite ongoing complaints of pain, registered staff failed to monitor and document the effectiveness of pain medications sixteen times

A. During the days following the injury, the resident continued to express ongoing pain. Review of the narcotic medication records, pain flow records,

electronic medication administration record (eMAR) notes; which revealed that registered staff did not monitor and document the effectiveness of the pain medications provided to the resident after pain was reported sixteen times.

Interview with the DOC on December 17, 2015, confirmed that staff did not monitor and document the effectiveness of medications, as listed above, when they were administered for complaints of pain made by resident #020.

B. The Policy for "Pain Management, NM-II-P010", effective from February 2009 to December 2015 directed registered staff to assess the residents' pain using the Pain Flow Record and Pain Assessment Tool and evaluate the resident's responses to the as needed pain (PRN) medication and document; and to notify the physican if the resident consistently reports moderate to horrible or excruciating pain for 24 to 48 hours and PRN medications are given more than three times a day.
i. Registered staff documented resident #020 as having ongoing moderate to severe pain following an injury on the pain flow record and progress notes; however, the physician was not notified of ongoing pain until seven days after a change in pain medication orders.
ii. More than three doses of PRN medications were administered to the resident five out of ten days following the injury; however, the physician was not notified until the tenth day.
iii. Review of the eMAR notes and Pain Flow Record identified that registered staff did not consistently document the resident's pain using the Pain Assessment Tool. Interview with DOC on December 17, 2015 confirmed that the pain flow record was not completed although as need analgesia was being administered for pain. Additionally, staff did not document the resident's pain using the Pain Flow Record and Pain Assessment Tool for each administration of analgesia, as required.

2. The plan of care for resident #64 identified that the resident had chronic pain related to a diagnosis of multiple chronic diseases. Interventions included but were not limited to administration of an opioid analgesia as needed, and to document the effectiveness. In December 2015, the eMARS identified that the resident received the opioid analgesia daily, approximately forty-six doses. Review of the progress notes and Pain Flow Record revealed that the resident's pain was not reassessed following administration of the opioid analgesia for pain, approximately thirty-five out of forty-six times. Interview with the DOC confirmed that registered staff should be documenting effectiveness of as

needed medication administration, as outlined in the policy. (528) [s. 134. (a)] (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 2016

Order # / Ordre no : 003

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

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 :

The licensee shall ensure the following:

a. that all residents, including resident #020, are provided with assistive devices that are in good repair, to ensure all residents are transported safely

b. that all residents who experience a change in condition, including resident #20, are assessed for pain using a clinically appropriate assessment tool. When pain is not relieved by initial intervention, these assessments are to be completed

c. that all residents, including resident #20, are reassessed for transfer status when there is a change in condition

Grounds / Motifs :

1. The licensee failed to ensure that resident #020 was free from neglect by the licensee or staff in the home as defined in O.Reg. 79/10, s.5, where 'neglect' means the failure to provide a resident with the treatment, care, services or assistance required for health,
safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In May 2015, resident #020 was sustained an injury while being transported by staff. The resident was sent to hospital for treatment. Review of the clinical health record indicated that the resident's assistive device had been broken for approximately two months, and continued to be broken an additional eleven days after the injury.

After returning to the home, the resident complained of moderate to severe pain with a change in weight bearing status. The staff continued to assist resident with transfers using a sit to stand lift for four days following the injury, and then was changed the resident to a full mechanical lift. The nursing team assessed a change in the area, which was not reported to the physician and no new interventions were put in place.

Eleven days after the injury the resident was diagnosed with injuries.

Interview with the DRC and PT confirmed that the resident was using an assistance device that was unsafe for two months prior to the injury and additional eleven days following the injury. It was also confirmed that the resident complained of ongoing moderate to severe pain with weight bearing, and the sit to stand lift continued to be used. It was also confirmed that the physician was not notified of ongoing complaints of moderate to severe pain, change in weight bearing status and assessment of the area of injury, until eleven days after the injury.

It was confirmed by the DRC that the home failed to provide resident #020 with the treatment, care and assistance they required for health, safety or well being and was neglected by the home. [s. 19. (1)] (581)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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