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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 03, 2018;	2018_551526_0006 (A2)	023590-17, 003138-18	Complaint

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

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Amended by AILEEN GRABA (682) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested extension of Compliance Order #002, #003, approved by SAO manager Karin Fairchild

Issued on this 3 day of July 2018 (A2)

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

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

Amended by AILEEN GRABA (682) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 16, 20, 21, 22, 26, 27, 28 and March 1, 2, 2018.

The following intakes were completed during this Complaint Inspection:

Log #023590-17 related to Skin and Wound, Reporting and Complaints, Medication Management

Log #003138-18 related to Skin and Wound, Hospitalization and Change in Condition, Pain Management

The following Inquiries were completed during this Complaint Inspection:

Log #022915-17 related to Personal Support Services, Reporting and Complaints

Log #024550-17 related to Dining and Snack Service

This inspection was conducted concurrently with Follow Up inspection log #000126-18, and Critical Incident System inspection log #024800-17.

Inspectors #694 and #697 were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care, Office Manager, Assistant Director of Care/Clinical Coordinator, Assistant Director of Care/Staff Development Coordinator, Assistant Dietary Manager, Registered Dietitian, Physiotherapy Assistant, Resident Assessment Coordinator, Renovation Project Manager, Registered staff, Personal Support Workers, residents and visitors.

During the course of this inspection, inspectors reviewed health records, policies and procedures, training records, nutrition and hydration documents, complaints investigations, medication incidents, meeting minutes, and observed residents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

Medication

Reporting and Complaints

Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised when their care needs changed.

A) According to health records, resident #005 was admitted to the home on a specified day in 2017. Staff documented that the resident’s condition deteriorated and notes were placed in a doctor’s book for when the doctor came to the home to see residents. A number of days after this deterioration began, a physician prescribed a diagnostic test and treatment but no assessment could be found upon review of the health records. The resident’s condition continued to deteriorate and registered staff applied a treatment without assessing the resident or notifying the physician. The resident was prescribed analgesia but no medical assessment of this further deterioration could be found in health records. The resident’s condition continued to deteriorate and they were discharged to hospital.

During interview, RN #116 stated that normally an issue could be placed into the doctor's book and the physician would address it when they were next in the home. However in this case, RN #116 and the Assistant Director of Care (ADOC)/Clinical Care Coordinator stated that when resident #005’s condition began and continued to deteriorate, registered staff should have notified the physician or Nurse Practitioner by phone rather than placing the issue in the doctor's book. The ADOC stated that staff should have assessed the resident and monitored their vital signs and pain.

During interview, the ADOC confirmed that resident #005 had not been assessed or their plan of care reviewed or revised when their health deteriorated.

B) According to health records, resident #003 was noted to have developed areas of altered skin integrity over a seven month time period and which affected the resident's mobility. The resident's plan of care directed staff in relation to resident #003’s ambulation and transferring but did not include any changes in mobility associated with their altered skin integrity.

During interview, personal support worker (PSW) #106 described resident #003's change in ambulation in relation to the altered skin integrity and confirmed that the care the resident was receiving was different than what was described in resident #003’s plan of care. During interview, the ADOC who updated plans of care in the home, confirmed that resident #003's written plan of care was not reviewed and revised when resident #003 sustained a change in their mobility. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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. (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. O. Reg. 79/10, s. 50 (1).

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;
O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies to position resident #005 to reduce and prevent skin breakdown and reduce and relieve pressure had been implemented.

The home's "Skin and Wound Care" policy number 05-07-21A dated October 2016 indicated that equipment, supplies, devices and positioning aids were readily

available as required to relieve pressure, treat pressure injuries, skin tears, bruises and wounds to promote healing.

According to their health records, resident #005 was admitted with their own mobility device, and was found to be at risk for pressure ulcers. Within a specified time after their admission to the home, resident #005 began to exhibit a number of alterations in skin integrity. During interview, Registered Nurse (RN) #116 stated that these areas deteriorated until the resident's discharge.

Review of health records identified that the need for strategies to position resident #005 to reduce and prevent skin breakdown and reduce and relieve pressure had been identified by the resident's decision makers and staff in the home, but these strategies had not been implemented. During interview, Registered Nurse #106 and the ADOC/Clinical Coordinator stated that pressure relieving devices were on back order. They also stated that resident #005's need for interventions to decrease the risk of altered skin integrity had been missed and that these strategies would have been beneficial to resident #005.

During interview, the ADOC/Clinical Coordinator confirmed that strategies to reduce and prevent skin breakdown and reduce and relieve pressure had not been implemented for resident #005. [s. 50. (1) 3.]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #003 had a history that placed them at risk for alterations in skin integrity.

a) According to health records, resident #003 was brought on two occasions by their decision makers to hospital for assessment of an area of altered skin integrity and they were prescribed a treatment to be administered. Review of the resident's health record indicated that no skin assessment by a member of the registered nursing staff had been completed upon resident #003's return from hospital.

b) On a specified day in 2018, resident #003 returned to the home after having a procedure at hospital and were prescribed dressings and treatments. Review of the resident's health record indicated that no skin assessment by a member of the registered nursing staff had been completed upon their return to the home.

c) Resident #003 was sent to hospital, for assessment of complications to their area of altered skin integrity. Review of documentation failed to identify a skin assessment upon their return from hospital.

During interview, the Assistant Director of Care (ADOC)/Clinical Care Coordinator stated that only residents who were in hospital for greater than 24 hours received a skin assessment upon return to the home. After reviewing the legislative requirement, they confirmed that a skin assessment should have been conducted when resident #003 returned from any hospital stay. [s. 50. (2) (a) (ii)]

3. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:

(i) Received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment;
(ii) Received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required;
(iii) Was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented; and
(iv) Was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Review of health records indicated that resident #003 was at risk for alterations in skin integrity and they developed three areas of altered skin integrity. These areas had deteriorated at the time of this inspection. Over a period of nine months, these areas were not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were not consistently reassessed weekly, treatment was not consistently provided to promote healing and prevent infection, and the resident was not assessed by a registered dietitian who was a member of the staff in the home when new areas of altered skin integrity were identified. This was confirmed during interview with the Director of Care (DOC).

B) According to health records, resident #005 was identified as being at risk for alterations in skin integrity upon admission to the home on a specified day in 2017. Review of health records indicated that they developed at least six areas of altered skin integrity within one month of their admission to the home.

Review of health records indicated that the identified areas of altered skin integrity had not been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and had not been reassessed at least weekly up to the time of the resident's discharge to hospital and treatment had not been immediately initiated to promote healing and prevent infection. During interviews, Registered Practical Nurse (RPN) #115, Registered Nurses (RNs) #102 and #106, and the Assistant Director of Nursing (ADOC)/Clinical Coordinator stated that these areas of altered skin integrity should have been assessed by registered staff when first identified and at least weekly. The ADOC stated that treatments and interventions to promote healing and prevent infection were not immediately initiated.

Record reviews failed to identify dietary assessments of these areas of altered skin integrity when they were first noted. Nutrition and hydration changes had not been made to the plan of care or implemented in relation to new wounds even though the resident was identified as being at risk for poor nutrition. The home's Registered Dietitian and ADOC/Clinical Coordinator stated during interview, that resident #005 had demonstrated altered skin integrity, they should have been assessed by an RD and had changes made to the plan of care and implemented as appropriate.

The ADOC/Clinical Coordinator confirmed that resident #005's areas of altered skin integrity had not been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, had not been reassessed at least weekly, treatments and interventions to promote healing and prevent infection were not immediately initiated and the resident did not receive an assessment by the RD when areas of altered skin integrity were first identified.

C) According to health records, resident #007 had areas of altered skin integrity upon admission to the home on a specified day in 2017. These areas and an additional nine areas of altered skin integrity developed and deteriorated over the next six weeks. Review of health records and staff interviews identified that these areas had not been consistently assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were not consistently reassessed weekly, and treatment was not consistently provided to promote healing and prevent infection. The resident was identified as being at high nutritional risk. They were not assessed by a registered

dietitian who was a member of the staff in the home on admission or when new areas of altered skin integrity were identified or when existing areas deteriorated. This was confirmed during interview with the Assistant Director of Care (ADOC)/Clinical Coordinator. [s. 50. (2) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

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 skin and wound care program, at a minimum, provides for strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to their health records resident #005 was admitted to the home on a specified day in 2017. Review of progress notes indicated that they developed new areas of altered skin that deteriorated while their general health status also deteriorated until the resident was sent to hospital.

Medical record review identified that pain assessments had not been completed on eight occasions when resident #005's pain was not relieved by initial interventions. Registered staff placed a note in the doctor's book and did not notify the physician or Nurse Practitioner (NP) when the resident's pain was not relieved or when the resident was not able to take the medication as prescribed to address their pain.

During interview, Registered Practical Nurse (RPN) #115, Registered Nurse (RN) #116, and the Assistant Director of Care (ADOC)/Clinical Coordinator stated that staff should assess and document a resident's pain on admission, quarterly and when their pain management was not effective. They stated that when resident #005's pain management was not effective, staff had failed to contact the physician or NP to ensure effective pain management. They confirmed that when resident #005's pain was not relieved by initial interventions, they were not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's 2017, Skin and Wound Program annual evaluation included a summary of the changes made and the date that those changes were implemented.

During interview the home's Assistant Director of Care (ADOC)/Clinical Coordinator stated that skin and wound issues were discussed quarterly during the Wounds Committee meetings, and that the program was evaluated annually in February of each year.

Review of the home's 2017 Skin and Wound Program evaluation conducted on February 14, 2018, included goals and objectives for the upcoming year and a list of residents who had alterations in skin integrity. Upon review, the ADOC confirmed that the goals and objectives from the 2016 and 2017 program evaluations were identical and included turning and repositioning residents with wounds every two hours, refer residents to the Registered Dietitian and the Occupational Therapist for seating assessments, to have ongoing education and training for registered staff on how to treat wounds accordingly, and to have weekly wound assessments.

However, the 2017, evaluation did not include changes made during 2017 or dates that changes had been made. The ADOC stated that changes made were not included in the annual evaluation and that the above mentioned issues continued to be challenges in the home. [s. 30. (1) 4.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Review of resident #003's health record indicated they developed three areas of altered skin integrity that worsened over a 10 month time period. Health records indicated that skin and wound treatments had not been documented 40 times during this time. Treatment and care of an additional area of altered skin integrity was not documented and the resident had a change in status that required additional treatment.

B) Review of resident #005's health record indicated they developed four areas of altered skin integrity that worsened over a one month time period. Review of electronic health records revealed that treatments for these areas were not documented 13 times.

C) Review of resident #007 received medications and multiple treatments in relation to alterations in skin integrity over a three month time period. Review of electronic health records indicated that treatments were not documented 17 times

and medications not documented 4 times during this time.

During interview, the Assistant Director of Care/Clinical Coordinator could not verify that unsigned treatments and medications had been given and stated that staff should be documenting treatments and medications administered using the home's electronic treatment and administration records in the home's documentation system. The ADOC confirmed that staff failed to document actions taken with respect to residents #003, #005, and #007 under a program, including assessments, reassessments, interventions and the resident's responses to interventions. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, and that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. In accordance with section section 221 of O. Reg 79/10, the licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in skin and wound care and that it be received annually.

The Assistant Director of Care (ADOC)/Staff Development Coordinator provided Long Term Care Home's Inspector #526 with documentation of staff's 2018 training for skin and wound care. During interview, the ADOC stated that staff do the training on their own and completed sign off sheets to indicate that their training was complete. The ADOC stated that the sheets were completed while inspectors were in the home during this inspection. They also stated that the training did not include any review of the home's skin and wound care policies. When asked for the 2017 annual training on the home's skin and wound program, the ADOC stated that zero percent (0%) of staff in the home had completed training related to skin and wound care in 2017. They stated that staff normally would receive this training in February 2017, but that it was forgotten last year. They confirmed that annual training for the home's skin and wound program had not been received by staff in the home during 2017. [s. 76. (7)]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the Skin and Wound Care to be received annually in accordance with section 221 of O.Reg. 79/10, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of the written complaint that was received relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant under subsection 101 (1).

During interview with resident #003's decision makers, they stated that they had complained to the home about resident #003 not receiving a treatment over a three week time period. Review of the home's complaints management notes indicated that the home had received this written complaint and provided a response.

During interview, the DOC reported that they considered the complainant's correspondance to be a written complaint. The DOC stated that they had not submitted a copy of the written complaint to the Director along with a written report documenting the response the licensee made to the complainant under section 101(1) of Regulation 79/10. The DOC also stated that it was not their practice to submit written reports to the Director and that they had not done so for any written complaint, even if it was related to a matter that the licensee should report to the Director under section 24 of the Act. [s. 103. (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, upon receipt of a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, that the licensee submits a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system included at least reviewing reports of any medication incidents and adverse drug reactions referred to in sections 135 (2) and (3) and identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During inspection about a medication error, the Director of Care (DOC) provided medication incident reports for incidents that occurred between September 5 and October 24, 2017. During interview the DOC stated that staff were required to complete a form when a medication incident had been discovered, and that these incidents were investigated with corrective actions. Review of the Nursing Practice Committee meeting minutes dated September 5 and December (no date) 2017, and the Medication Management Committee meeting minutes dated November and December 2017, and the Professional Advisory Committee (interdisciplinary team) meeting minutes dated September 19 and December 12, 2017, did not include a review of these reports and did not identify specific changes in relation to each incident to improve the system according to evidence-based practices.

During interview, the home's Assistant Director of Care (ADOC)/Clinical Coordinator stated that individual medication incidents were not reviewed quarterly by an interdisciplinary team with specific reference to identifying changes to improve the system or in accordance with evidence-based practices. [s. 115. (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 quarterly evaluation of the medication management system includes at least, reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #8: 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 residents in accordance with the directions for use specified by the prescriber.

According to their health record, resident #003 had three areas of altered skin integrity that deteriorated over a seven month time period. They were prescribed a medication by a specialist physician. A faxed notification was sent to the home and a written notification delivered to Registered Practical Nurse (RPN) #111 by the resident's decision makers. The home's investigative notes, and interviews with the Director of Care (DOC) indicated that the prescription was filed into the resident's chart rather than being processed. The error was identified when the resident's decision makers asked why the resident had not received this medication.

During the time when the resident should have received the medication, review of skin assessments identified that the resident's areas of altered skin integrity had deteriorated. The DOC stated that resident #003 had not received a medication as prescribed over a three week time-period and this resulted in a risk of harm to the resident. [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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: 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 were documented, reviewed and analyzed, (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b).

According to progress notes and interview with the Director of Care (DOC), a specialist physician prescribed a medication to resident #003 and the resident's decision makers observed that the resident had not received the medication over a three week time period. According to progress notes and interview with the DOC, the home received a faxed prescription and a prescription was also handed to staff in the home. However, the medication was not transcribed and the resident did not receive it.

The DOC stated that registered staff had not documented the incident using the home's medication incident report and also that no corrective action had been taken to prevent a similar incident from occurring in the home. Review of the home's medication incident documents, correspondence with resident #003's decision makers, quarterly medication management committee meeting minutes and the December 2017 Nursing Practice Committee meeting indicated that the medication incident had not been documented, reviewed or analyzed, and corrective action had not been taken to prevent this type of incident from occurring again in the home. This was confirmed by the DOC. [s. 135. (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 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), to be implemented voluntarily.

Issued on this 3 day of July 2018 (A2)

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

Ministère de la Santé et des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by AILEEN GRABA (682) - (A2)

Inspection No. / No de l'inspection : 2018_551526_0006 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 023590-17, 003138-18 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jul 03, 2018;(A2)

Licensee / Titulaire de permis : Heritage Green Nursing Home
353 Isaac Brock Drive, STONEY CREEK, ON, L8J-2J3

LTC Home / Foyer de SLD : Heritage Green Nursing Home
353 Isaac Brock Drive, STONEY CREEK, ON, L8J-2J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : J. Scott Kozachenko

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To Heritage Green Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with section 6. (10) of the LTCHA, 2007.

Specifically the licensee must do the following:

1. Contact the Physician or Registered Nurse in Extended Class directly for immediate medical assessment when any resident's care needs change such as when the resident has developed signs of infection, when their level of consciousness changes, when they stop voiding, or when they are unable to swallow.

2. Reassess resident #003 and review and revise their plan of care as necessary.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised when their care needs changed.

A) According to health records, resident #005 was admitted to the home on a specified day in 2017. Staff documented that the resident's condition deteriorated and notes were placed in a doctor's book for when the doctor came to the home to see residents. A number of days after this deterioration began, a physician prescribed a diagnostic test and treatment but no assessment could be found upon review of the health records. The resident's condition continued to deteriorate and registered staff applied a treatment without assessing the resident or notifying the physician. The resident was prescribed analgesia but no medical assessment of this further deterioration could be found in health records. The resident's condition continued to deteriorate and they were discharged to hospital.

During interview, RN #116 stated that normally an issue could be placed into the doctor's book and the physician would address it when they were next in the home. However in this case, RN #116 and the Assistant Director of Care (ADOC)/Clinical Care Coordinator stated that when resident #005's condition began and continued to deteriorate, registered staff should have notified the physician or Nurse Practitioner by phone rather than placing the issue in the doctor's book. The ADOC stated that staff should have assessed the resident and monitored their vital signs and pain.

During interview, the ADOC confirmed that resident #005 had not been assessed or their plan of care reviewed or revised when their health deteriorated.

B) According to health records, resident #003 was noted to have developed areas of altered skin integrity over a seven month time period and which affected the resident's mobility. The resident's plan of care directed staff in relation to resident #003's ambulation and transferring but did not include any changes in mobility associated with their altered skin integrity.

During interview, personal support worker (PSW) #106 described resident #003's change in ambulation in relation to the altered skin integrity and confirmed that the care the resident was receiving was different than what was described in resident #003's plan of care. During interview, the ADOC who updated plans of care in the home, confirmed that resident #003's written plan of care was not reviewed and revised when resident #003 sustained a change in their mobility.

The severity of this issue was determined to be level 3 as there was actual harm to residents. The scope of this issue was a level 2 as it related to two of three residents

reviewed. The home had a compliance history of 5 with multiple non compliances with at least one related to the current area of concern that included:
- Written Notice (WN) issued March 5, 2015 (2015_250511_0005);
- Director's Review (DR), Compliance Order (CO), and Voluntary Plan of Correction (VPC) issued March 14, 2016 (2016_323130_0007);
- DR, VPC issued February 9, 2017 (2017_570528_0005); and
- DR, VPC issued on April 26, 2017 (2017_574586_0009) (526)

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

May 31, 2018(A1)

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. 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 :

The licensee must be compliant with section 50. (2) of O. Reg. 79/10.

Specifically the licensee must,
A) for resident #003 and any residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears, or wounds:

1. Conduct 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 when altered skin integrity is identified;

2. Provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required including but not limited to administration of treatments, and the use of equipment, supplies, devices and positioning aids such as tilt chairs, therapeutic surfaces, and heel posies as determined by residents' individualized assessments;

3. Ensure the resident is assessed by a registered dietitian who is a member of the staff of the home; and

4. Reassess and document the assessment of the resident's altered skin integrity at least weekly by a member of the registered nursing staff, if clinically indicated.

B) A skin assessment for resident #003 and all residents at risk of altered in skin integrity shall be conducted by a member of the registered nursing staff upon any return of the resident from hospital.

C) Retrain, in person, all direct care staff on the home's skin and wound care policies and procedures to include skin and wound prevention, assessment, reassessment, Registered Dietitian referral and the provision of treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff

upon any return from hospital.

Resident #003 had a history that placed them at risk for alterations in skin integrity.

a) According to health records, resident #003 was brought on two occasions by their decision makers to hospital for assessment of an area of altered skin integrity and they were prescribed a treatment to be administered. Review of the resident's health record indicated that no skin assessment by a member of the registered nursing staff had been completed upon resident #003's return from hospital.

b) On a specified day in 2018, resident #003 returned to the home after having a procedure at hospital and were prescribed dressings and treatments. Review of the resident's health record indicated that no skin assessment by a member of the registered nursing staff had been completed upon their return to the home.

c) Resident #003 was sent to hospital, for assessment of complications to their area of altered skin integrity. Review of documentation failed to identify a skin assessment upon their return from hospital.

During interview, the Assistant Director of Care (ADOC)/Clinical Care Coordinator stated that only residents who were in hospital for greater than 24 hours received a skin assessment upon return to the home. After reviewing the legislative requirement, they confirmed that a skin assessment should have been conducted when resident #003 returned from any hospital stay. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:

(i) Received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment;
(ii) Received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required;
(iii) Was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented; and
(iv) Was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Review of health records indicated that resident #003 was at risk for alterations in skin integrity and they developed three areas of altered skin integrity. These areas had deteriorated at the time of this inspection. Over a period of nine months, these areas were not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were not consistently reassessed weekly, treatment was not consistently provided to promote healing and prevent infection, and the resident was not assessed by a registered dietitian who was a member of the staff in the home when new areas of altered skin integrity were identified. This was confirmed during interview with the Director of Care (DOC).

B) According to health records, resident #005 was identified as being at risk for alterations in skin integrity upon admission to the home on a specified day in 2017. Review of health records indicated that they developed at least six areas of altered skin integrity within one month of their admission to the home.

Review of health records indicated that the identified areas of altered skin integrity had not been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and had not been reassessed at least weekly up to the time of the resident's discharge to hospital and treatment had not been immediately initiated to promote healing and prevent infection. During interviews, Registered Practical Nurse (RPN) #115, Registered Nurses (RNs) #102 and #106, and the Assistant Director of Nursing (ADOC)/Clinical Coordinator stated that these areas of altered skin integrity should have been assessed by registered staff when first identified and at least weekly. The ADOC stated that treatments and interventions to promote healing and prevent infection were not immediately initiated.

Record reviews failed to identify dietary assessments of these areas of altered skin integrity when they were first noted. Nutrition and hydration changes had not been made to the plan of care or implemented in relation to new wounds even though the resident was identified as being at risk for poor nutrition. The home's Registered Dietitian and ADOC/Clinical Coordinator stated during interview, that resident #005 had demonstrated altered skin integrity, they should have been assessed by an RD and had changes made to the plan of care and implemented as appropriate.

The ADOC/Clinical Coordinator confirmed that resident #005's areas of altered skin integrity had not been assessed by a member of the registered nursing staff, using a

clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, had not been reassessed at least weekly, treatments and interventions to promote healing and prevent infection were not immediately initiated and the resident did not receive an assessment by the RD when areas of altered skin integrity were first identified.

C) According to health records, resident #007 had areas of altered skin integrity upon admission to the home on a specified day in 2017. These areas and an additional nine areas of altered skin integrity developed and deteriorated over the next six weeks. Review of health records and staff interviews identified that these areas had not been consistently assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were not consistently reassessed weekly, and treatment was not consistently provided to promote healing and prevent infection. The resident was identified as being at high nutritional risk. They were not assessed by a registered dietitian who was a member of the staff in the home on admission or when new areas of altered skin integrity were identified or when existing areas deteriorated. This was confirmed during interview with the Assistant Director of Care (ADOC)/Clinical Coordinator.

The severity of this issue was determined to be level 3 as there was actual harm to residents. The scope of the issue was a level 3 as it related to three of three residents. The home had a level 4 compliance history as they had ongoing non compliance with this section as follows:
- Compliance Order (CO) issued on March 5, 2015 (2015_250511_0005). (526)

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

Sep 17, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must comply with section 52. (2) of O. Reg. 79/10.

Specifically the licensee must:

1. Assess residents known to have pain if their pain is not relieved by initial interventions, using a clinically appropriate assessment instrument specifically designed for this purpose;

2. Ensure that a resident is reassessed by a Physician or Registered Nurse in Extended Class (NP) and the plan of care reviewed and revised when any resident's pain is not relieved by initial interventions, or when the need for a different route of analgesia administration is identified; and

3. Administer as needed (PRN) analgesia and assess and document its effectiveness.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to their health records resident #005 was admitted to the home on a specified day in 2017. Review of progress notes indicated that they developed new areas of altered skin that deteriorated while their general health status also deteriorated until the resident was sent to hospital.

Medical record review identified that pain assessments had not been completed on eight occasions when resident #005's pain was not relieved by initial interventions. Registered staff placed a note in the doctor's book and did not notify the physician or Nurse Practitioner (NP) when the resident's pain was not relieved or when the resident was not able to take the medication as prescribed to address their pain.

During interview, Registered Practical Nurse (RPN) #115, Registered Nurse (RN) #116, and the Assistant Director of Care (ADOC)/Clinical Coordinator stated that staff should assess and document a resident's pain on admission, quarterly and when their pain management was not effective. They stated that when resident #005's pain management was not effective, staff had failed to contact the physician or NP to ensure effective pain management. They confirmed that when resident #005's pain was not relieved by initial interventions, they were not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity of this issue was determined to be level 3 as there was actual harm to resident #005. The scope of the issue was level 1 as it related to one out of three residents. The home had a level 4 compliance history as they had ongoing non compliance with this section as follows:
- a Voluntary Plan of Correction (VPC) issued March 24, 2016 (2016_323130_0007). (526)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sep 17, 2018(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3 day of July 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AILEEN GRABA - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Service Area Office / Bureau régional de services : Hamilton