Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 20, 2021	2021_857129_0001 (A1)	020044-20, 021276-20, 021858-20, 023184-20, 001603-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Fox Ridge Care Community
389 West Street Brantford ON N3R 3V9

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

Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee order report has been revised to reflect wording and steps changes to Order #001. The Critical Incident System inspection, 2021_857129_0001 was completed on March 18, 2021.

A copy of the revised report is attached

Issued on this 20th day of May, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 19, 23, 24, 25, 26, March 2, 3, 4, 10, 11, 16, 17, 18, 2021.

The following intakes related to falls were inspected: 001603-21, 023184-20, 021858-20, 020044-20 and 021275-20.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Practical Nurses, Registered Dietitian, RAI-Coordinator, Assistant Director of Care, Director of Care and the Executive Director.

During the course of this inspection residents were observed, electronic clinical records were reviewed, fluid intake records were reviewed, training records were reviewed, fall program evaluation was reviewed and the licensee's policies related to falls, hydration, indwelling catheter care and documentation were reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration

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

6 WN(s)
3 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure the plans of care for five residents were based on an interdisciplinary assessment of their risk of falls.

i)The licensee failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of their risk of falls.

A Falls Risk assessment was initiated for the resident on admission to the home. The assessment form indicated a registered nurse had selected nine general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what effect the selected data points may have had for the resident related to falling and there were no records to indicate other disciplines participated in the falls risk assessment.

The DOC verified the general data points selected did not identify resident specific conditions or circumstances, there were no records to support the application of clinical decision making and there were no records to support that other disciplines participated in the falls risk assessment.

The DOC also confirmed it was the practice in the home that nursing staff completed the falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident's plan of care to reduce the chance the resident would fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

ii)The licensee failed to ensure that a second resident's plan of care was based

on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 13 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident’s specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have had for the resident related to falling and there were no records to indicate that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee’s Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident’s plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

iii)The licensee failed to ensure that a third resident’s plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 11 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident’s specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have had for the resident related to falling and there were no records to indicate that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls

risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the residents' plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

iv)The licensee failed to ensure that a fourth resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 14 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have for the resident related to falling and there were no records to indication that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident's plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management

policy and an interview with the DOC.

v)The licensee failed to ensure that a fifth resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 13 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have for the resident related to falling and there were no records to indicate that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the residents' plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that post fall assessments were completed when four residents fell.

The licensee's Falls Prevention and Management policy directed staff to use the electronic Post Fall Incident form to complete a post fall assessment when a resident had fallen.

i)The licensee failed to ensure a post fall assessment was completed when one resident fell.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the Post Fall Incident form confirmed staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the required documentation on the Post Fall Incident forms.

Staff did not conduct post fall assessments after this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident forms the way they were intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

ii)The licensee failed to ensure a post fall assessment was completed when a second resident fell.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the circumstances surrounding the fall and a section related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident forms.

Staff did not complete post fall assessments after this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident forms the way they were intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

iii)The licensee failed to ensure a post fall assessment was completed when a third resident fell.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the fall incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident forms.

Staff did not complete post fall assessments when this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident forms the way they were intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

iv)The licensee failed to ensure a post fall assessment was completed when a fourth resident fell.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident form.

The failure of staff to implement the Post Fall Incident form the way it was intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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 staff collaborated in the development of a resident's care plan related to minimum fluid requirements.

The Registered Dietitian (RD) assessed this resident and identified the daily minimum fluid servings for the resident.

The RD confirmed they did not document the daily fluid servings requirements in the resident’s care plan and as a result, nursing staff would not have been aware of the daily fluid servings the resident was to receive.

Fluid intake records indicated that the resident drank less that the minimum fluid

servings the RD had identified, for 21 of 24 days.

The gap in ensuring that the minimum fluid requirements were documented in the resident's care plan increased the risk that the resident would not receive the daily fluid requirement identified by the RD and may experience dehydration.

Sources: the resident's care plan, electronic Fluid Intake records, nutritional assessment and an interview with the RD. [s. 6. (4) (b)]

2. The licensee failed to ensure that care specified in the plan of care related to falls prevention was provided to a resident.

The resident had been assessed at risk for falling and had fallen. The resident's care plan had been revised on a date in 2020 and two care interventions were to be put in place for the resident.

Documentation made by registered staff in a Post Fall Incident form indicated that one of the care interventions identified in the care plan had not been in place when the resident experienced a fall.

Documentation made by registered staff in a second Post Fall Incident form indicated that one of the care interventions identified in the care plan had not been in place when the resident experienced a second fall.

At the time of this inspection, observations of the resident confirmed the two care interventions identified in the plan of care were not in place were not in, as specified in the care plan.

The Assistant Director of Care (ADOC) also confirmed the two care interventions identified in the care plan were not in place at the time of the observation.

The failure of staff to ensure the two care interventions were in place, increased the risk that the resident would sustain injuries from falling.

Sources: The resident's care plan and progress notes, observations of the resident, electronic Post Fall Incident Forms and interview with the ADOC.[s. 6. (7)]

3. The licensee failed to ensure staff documented the provision of fluids to a

resident.

Documentation indicated that registered staff identified a resident was not eating or drinking well and initiated a referral to the RD.

Electronic records of the resident's fluid intake for over a two-month period were reviewed. The records indicated that staff had not documented the provision of fluids to the resident during scheduled meal and snack time on 17 occasions.

The DOC confirmed that based on the records reviewed, staff had not consistently documented the provision of fluids to the resident.

The gaps in ensuring the provision of fluid to the resident was documented in the clinical record resulted in there not being an accurate record of the amount of fluid the resident drank which may compromise the resident's hydration status.

Sources: electronic fluid intake records and interview with DOC. [s. 6. (9) 1.]

4. The licensee failed to ensure that a resident's plan of care was reviewed and revised when it was identified that there had been a change in two areas of care.

i)The licensee failed to ensure a resident's plan of care was reviewed and revised when the resident was noted to not be drinking well.

RPN #105 confirmed that the resident had not been drinking well.

The home's policy "Hydration and Nutrition Monitoring", directed that any resident who drank six fluid servings or less a day, for three consecutive days was to be assessed for signs and symptoms of dehydration.

An assessment was completed by the RD and they identified the minimum daily fluid requirements for the resident as nine serving a day.

Daily fluid intake records completed by PSW staff confirmed that the resident's fluid intake had changed. A review of the records indicated the resident had not drank the minimum fluid requirements identified in the home's policy or in the RD's assessment for 21 of 24 days.

Daily fluid intake summary records completed by registered staff confirmed that

the resident's fluid intake had changed. Registered staff were responsible to review the amount of fluid the resident drank every 24 hours and document when a resident had not consumed fluid levels identified in the home's policy. A review of those records indicated the resident had not drank adequate amounts of fluid on 15 of 24 days.

Referrals submitted by registered staff to the Registered Dietitian (RD) confirmed that resident #001's fluid intake had changed. A review of the records indicated that four referrals over a 23-day period were sent to the RD. The referrals indicated the resident had unexpected changes in their fluid intake and that the resident showed signs of dehydration.

The DOC and the RD confirmed that the resident's plan of care did not include evidence that care staff had been directed to offer additional fluids, there was no record that additional fluids were taken and there had been no changes to the resident's care plan when staff providing care to the resident were aware that the resident's condition had changed and they were not drinking the required amounts of fluid.

Failure of staff to ensure the resident's care plan was revised to include care interventions to manage a change in the resident's fluid intake contributed to an ongoing decline in the resident's hydration status.

Sources: observations of the resident, electronic care plan, electronic fluid intake records, Dining Room forms, nutritional referral documents, Hydration and Nutrition Monitoring policy and interviews with the DOC and the RD.

ii)The licensee failed to ensure a resident's plan of care was reviewed and revised when the resident experienced falls.

The resident was assessed to be at risk for falling and a written plan of care was developed.

The resident began to experience falls and fell four times. Records indicated two of the falls resulted in the resident receiving injuries.

A review the resident's care plan confirmed that staff had not revised the resident's care plan after the first, second or third fall.

The DOC reviewed the resident's care plan and verified that there had been no additional care interventions added to the plan following the first, second or third fall the resident experienced.

Failure of staff to review and revise the resident's care plan when they began to fall resulted in the resident continuing to fall.

Sources: the resident's electronic clinical notes, care plan, Post Fall Incident forms and an interview with the DOC. [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 and ensuring staff collaborate in the development of the plan of care, care specified in the plan is provided to residents, staff document the provision of care to residents and the plan of care is reviewed and revised when the residents care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the staff complied with the policy related to documenting a resident's fluid intake and the policy related to the management of falls.

i)The licensee failed to ensure staff complied with the Nutrition and Hydration Monitoring policy.

LTCHA s. 11 (1)(b) requires the licensee to have an organized program hydration to meet the needs of the residents.

O. Reg. 79/10, s. 68 (1) (b) and O. Reg. 79/10, s. 68 (2) requires that the program includes the development and implementation of policies and procedures related to hydration.

Specifically, staff did not comply with the licensee's policy "Hydration and Nutrition Monitoring", dated November 2020.

The policy directed that all residents' food and fluid intake would be monitored and recorded daily as a number of fluid servings.

Staff failed to comply with the policy when electronic fluid intake records confirmed that staff had not documented all fluids consumed by a resident on seven identified days.

The DOC confirmed that based on the records reviewed, staff had not consistently documented the provision of fluids to the resident.

Sources: Nutrition and Hydration Monitoring policy, electronic fluid intake records and an interview with the DOC.

ii)The licensee failed to ensure the policy related to falls prevention and management was complied with.

O.Reg. 79/10 s. 48 (1) 1 requires a falls prevention and management program be developed and implemented.

O. Reg 79/10 s. 30(1) 1 requires that each of the interdisciplinary programs under section 48 of the regulation there must be written descriptions of the program that include relevant policies.

Specifically, staff did not comply with the licensee's Falls Prevention and Management policy.

The licensee's Falls Prevention and Management policy directed the DOC would determine a communication process by which residents at moderate or high risk for falling would be easily identified to the entire care team.

Clinical documents identified a resident was at a high risk for falling. Observations of the resident and their room area were made, and it was noted that there were no markings outside their room or in their room that would indicate the resident had been assessed at a high risk for falls.

Clinical documents identified another resident was at a high risk for falling. Observations of the resident and their room area were made, and it was noted that there were no markings outside their room or in their room that would indicate the resident had been assessed at a high risk for falls.

The DOC confirmed there was not a communication process in place to easily alert the entire care team when a resident had been assessed as a high or moderate risk for falls.

Failure to ensure there a communication process was in place to alert the entire care team that a resident had been identified at a moderate or high risk for falling, increased the likelihood that the above noted residents may have been placed in situations that could be unsafe for them.

Sources: Observations of two resident room areas, Falls Risk Assessments, Falls Prevention and Management policy and an interview with the DOC.

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 and ensuring that staff comply with the licensee's policies and procedures, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure staff who provided care to a resident implemented infection prevention and control practices related to medical device.

It was observed that parts of the medical device, used by this resident were lying on a soiled mat that had been placed beside the resident's bed. At the time of this observation, RPN #105, who was also in the room, acknowledged how the parts of the medical device had been positioned.

RPN #105 indicated they were aware that staff had not ensured the medical device had been left in the proper position for the operation of the device and the prevention of infection.

The Assistant Director of Care (ADOC), who was the Infection Prevention and Control (IPAC) lead for the home, confirmed staff had not implemented expected IPAC practices when parts of the medical device were left in contact with the soiled mat.

Failure of staff to implement the expected IPAC practices increased the risk that this resident may have been exposed to an infection. [s. 229. (4)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (1) A licence is subject to the conditions, if any, that are provided for in the regulations. 2007, c. 8, s. 101. (1).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licensee was subject, related to the completion of a significant change in status assessment for a resident.

The Long-Term Care Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health Integration Act, 2006, required all licensees to implement the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) system.

The "Resident Assessment Instrument (RAI) RAI-MDS 2.0 User Manual - Canadian Version" directed: A Significant Change in Status Full Assessment must be completed by the 14th day following the determination that a significant change in the resident's health status had occurred. The manual defines "significant change" as a major change in the resident's status that is not self-limiting, impacts more than one area of the resident's health status and requires interdisciplinary review and/ or revision of the care plan.

A resident fell which resulted in the resident sustaining an injury.

Clinical documentation by registered staff, a dietary referral and changes to the plan of care indicated the resident's health status changed in relation to four care areas.

A review of the electronic record confirmed that a significant change in status assessment had not been initiated.

Registered staff #104 confirmed a significant change in status assessment had not been initiated.

Failure of staff to complete the significant change in status assessment increased the risk that interdisciplinary care interventions would not be put in place to manage and support the changes in their health status this resident experienced.

Sources: the resident's care plan, electronic progress notes, Dietary referral, electronic MDS assessments as well as, Resident Assessment Instrument Minimum Data Set 2.0 Funding policy, Resident Assessment Instrument (RAI) RAI-MDS 2.0 User Manual and an interview with staff #104. [s. 101. (1)]

Issued on this 20th day of May, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)
Inspection No. / No de l'inspection :	2021_857129_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020044-20, 021276-20, 021858-20, 023184-20, 001603-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 20, 2021(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fox Ridge Care Community 389 West Street, Brantford, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Croley

Ontario

Ministry of Long-Term Care

Ministère 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 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

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

(A1)
The licensee must comply with s. 26(3) of O. Reg. 79/10

Specifically, the licensee must:

1. Review and redevelop the Falls Prevention and Management policy to ensure:
a) A resident's risk of falling is based on an interdisciplinary assessment; and
b) The interdisciplinary assessment is documented in the clinical record.

2. Provide training to all registered staff who are responsible for the coordination of the interdisciplinary fall risk assessments, based on the redeveloped policy. Training is to include:
a) The licensee's process for completing an interdisciplinary fall risk assessment; and
b) The licensee's requirement for documentation of the completed fall risk assessment in the clinical record.

3. Maintain documentation related to the content of the above noted training and the names of staff who participated in the training.

4. Develop and implement an auditing process to ensure interdisciplinary fall risk assessments are completed and resident care plans have been updated to reflect the outcome of the completed assessment.

5. Maintain records of the completed audits and continue to audit until no further concerns arise with the completion of the interdisciplinary fall risk assessment and the development of resident care plans that are based on the completed assessments.

Grounds / Motifs :

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

1. The licensee failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of their risk of falls.

A Falls Risk assessment was initiated for this resident on admission to the home. The assessment form indicated a registered nurse had selected nine general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what effect the selected data points may have had for the resident related to falling and there were no records to indicate other disciplines participated in the falls risk assessment.

The DOC verified the general data points selected did not identify resident specific conditions or circumstances, there were no records to support the application of clinical decision making and there were no records to support that other disciplines participated in the falls risk assessment.

The DOC also confirmed it was the practice in the home that nursing staff completed the falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident's plan of care to reduce the chance the resident would fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

(129)

2. The licensee failed to ensure that a second resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 13 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have had for the resident related to falling and there were no records to indicate that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident's plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.
(129)

3. The licensee failed to ensure that a third resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 11 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have had for the resident related to falling and there were no records to indicate that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the residents' plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.
(129)

4. The licensee failed to ensure that a fourth resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 14 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have for the resident related to falling and there were no records to indication that other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the resident's plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.
(129)

5. The licensee failed to ensure that a fifth resident's plan of care was based on an interdisciplinary assessment of the resident's risk of falls.

A Falls Risk assessment was initiated for this resident. The assessment form indicated a registered nurse had selected 13 general data points available on the form. The program then calculated the resident to be a high risk for falls.

There were no records to support that this resident's specific conditions or circumstances had been reviewed or analyzed, what impact the selected data points may have for the resident related to falling and there were no records to indicate that

other disciplines participated in the falls risk assessment.

The DOC verified it was the practice in the home that nursing staff completed falls risk assessments.

The licensee's Falls Prevention and Management policy directed that a nurse was to conduct a fall risk assessment and did not indicate the assessment was to be an interdisciplinary assessment.

Failure of staff to complete an interdisciplinary falls risk assessment increased the risk that specific issues that may contribute to the risk that this resident may fall, would not be identified and would not become part of the residents' plan of care to minimize the risk of injury from a fall.

Sources: electronic Falls Risk Assessment, Falls Prevention and Management policy and an interview with the DOC.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm as the five residents were more likely to fall because interdisciplinary assessments were not completed to identify individual factors that place residents at risk for falling and resident plans of care were not based on individual factors related to falling.

Scope: The scope of this non-compliance was widespread, as completion of interdisciplinary falls risk assessments and corresponding plans of care were not completed for five of five residents reviewed during this inspection.

Compliance History: One voluntary plan of corrective action (VPC) was issued to the same subsection being cited in the past 36 months. Additionally, seven written notifications (WN), nineteen voluntary plans of correction (VPC) and nine compliance orders were issued to the home related to different sections of the legislation in the past 36 months.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2021

Ontario

Ministry of Long-Term Care

Ministère 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

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 49(2) of O. Reg. 79/10

Specifically, the licensee must:

-Ensure post fall assessments are implemented and completed as they were intended to be.

-Develop and implement an auditing process to ensure all post fall assessments are completed as they were intended to be.

-Document the audits and continue the auditing process until no further concerns arise with the completion of post fall assessments.

-

Grounds / Motifs :

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

1. The licensee failed to conduct a post fall assessment when a resident fell.

The licensee's Falls Prevention and Management policy directed staff to use the electronic Post Fall Incident Form as the post fall assessment.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the Post Fall Incident form confirmed staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the required documentation on the Post Fall Incident forms.

Staff did not conduct post fall assessments after this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident form the way it was intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

(129)

2. The licensee failed to conduct a post fall assessment when a second resident fell.

The licensee's falls prevention and management policy directed staff to use the electronic Post Fall Incident Form as the post fall assessment.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the circumstances surrounding the fall and a section related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident forms.

Staff did not complete post fall assessments after this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident form the way it was intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.
(129)

3. The licensee failed to ensure a post fall assessment was completed when a third resident fell.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

A Post Fall Incident form was initiated when this resident fell a second time. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the fall incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident forms.

Staff did not complete post fall assessments when this resident fell on two occasions, when they failed to implement the Post Fall Incident forms the way they were intended to be implemented.

The failure of staff to implement the Post Fall Incident form the way it was intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.
(129)

4. The licensee failed to ensure a post fall assessment was completed when a fourth resident fell.

The licensee's falls prevention and management policy directed staff to use the electronic Post Fall Incident Form as the post fall assessment.

A Post Fall Incident form was initiated when this resident fell. A review of the form confirmed that staff had not completed a section of the form related to the immediate actions put in place to prevent a recurrence of the incident, as was required.

The DOC acknowledged that staff had not completed the Post Fall Incident form.

The failure of staff to implement the Post Fall Incident form the way it was intended to be implemented contributed to ongoing falls this resident experienced.

Sources: Falls Prevention and Management policy, electronic Post Fall Incident forms and an interview with the DOC.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm as the four residents where more likely to continue to fall when post fall assessments did not identify the circumstances of the fall or what actions were taken to prevent a recurrence.

Scope: The scope of this non-compliance was widespread, as post fall assessments were not completed as they were intended to be for four of five residents reviewed during this inspection.

Compliance History: Seven written notifications (WN), nineteen voluntary plans of correction (VPC) and nine compliance orders (CO) were issued to the home related to different sections of the legislation in the past 36 months.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2021

Ontario

Ministry of Long-Term Care

Ministère 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(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

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 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:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 20th day of May, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Ontario

Ministry of Long-Term Care

Ministère 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 Service Area Office