Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2013	2012_122156_0024	H-002114-12	Follow up

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

CAROL POLCZ (156), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 1, 2, 7, 8, 16, 19, 20, 21, 22, 23, 26, 28, 2012

This inspection was a follow up to orders left during the RQI August 2011; Log #H-002114-12.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, Registered Dietitian, Personal Support Workers (PSW's), residents and family, Environmental Services Supervisor and staff, Food Services Supervisor (FSS)

During the course of the inspection, the inspector(s) observed resident care and privacy, reviewed resident clinical records, reviewed staffing schedules and orientation, reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Continence Care and Bowel Management

Falls Prevention

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 plan of care for each resident did not provide clear directions to staff and others who provide direct care to the resident.
Resident #007 had a diet order change in October 2012 to regular texture, however, the care plan indicated the resident required a minced texture. One area of the residents' care plan indicated that the resident was at moderate nutritional risk, however, another area indicated high nutritional risk.
Resident #001 had a diet order for NPO (nothing by mouth) however, the care plan indicated that registered staff were to monitor for changes in blood glucose and if necessary provide a specified treatment. The care plan did not provide specific information related to the administration of this treatment. [s. 6. (1) (c)]

2. The plan of care for residents were not reviewed and revised when the residents' care needs changed.
In October 2012, resident #011 was noted to have suffered a change in condition. The resident's Power of Attorney (POA) requested that the resident be kept in bed and requested that the resident be kept comfortable. The resident's physician prescribed a narcotic medication to be administered subcutaneously via a butterfly to maintain the resident's comfort. The document that the home refers to as the care plan was not updated to include these interventions or the change in the resident's condition.
In October 2012 the progress notes indicated that the resident had developed a pressure area. The care plan was not updated to include this area of skin breakdown until November 2012.
In November 2012, the resident's condition deteriorated further and the resident was deemed by the physician with input from the POA to be palliative. The care plan for the resident was not reviewed and revised to include the resident's palliative status or their current needs with regards to care until several days later in November 2012.
The care plan was not revised to include the changes in the resident's care needs related to activities of daily living (toileting, hygiene and grooming, eating) or the changes to the resident's behavioural care plan that were no longer applicable.
The nutritional care plan for the resident was noted to be last reviewed in August 2012 and did not include current interventions with regards to their nutritional needs or palliative status. The nutritional care plan still indicated that the resident uses a plate guard stabilizer and built-up utensils, a lipped plate at meals, that the resident could eat by his/herself as long as the resident was set up and that there was a need to discourage the resident from snacking on sandwiches at night and eating extra desserts. Staff interviewed confirmed that the resident is no longer able to feed him/herself and requires total assistance to eat meals. [s. 6. (10) (b)]

3. Resident #011 was currently receiving the assistance of a specified nurse to feed at breakfast, lunch and supper, however, this information was not included in the resident's care plan. [s. 6. (10) (b)]

4. The plan of care for resident #020 was not reviewed and revised when the resident's care needs changed. It was noted that the resident experienced a change in condition in October 2011 and was transferred to hospital. Upon return from hospital, the care plan was not updated to include the resident's risk for the change in condition nor were there any interventions identified to direct staff related to monitoring activities or how to respond if this change should occur.
The care plan for resident #006 indicated to provide the resident with 235ml Ensure Plus at AM and PM snacks as well 250 cc chocolate milk at HS snack, however, the most current RAP (resident assessment protocol) dated October 11, 2012 indicated that these were discontinued. The care plan also indicated a goal to gain weight, however, the RAP indicated that this was not longer realistic and that weight maintenance was the goal. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

---

1. The licensee did not ensure that each resident of the home was bathed, at a minimum of twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. a) The care plan for resident #007 indicated that the resident was to have a shower on Tuesdays and Fridays – the resident prefers a shower but would have a bath. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a tub bath or a shower on specified dates in October 2012. Documentation was confirmed by the ADOC.
b) The care plan for resident #006 indicated that the resident was to have a shower Wednesdays and Fridays. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a shower on specified dates in October 2012. Progress notes indicated that the resident received a bed bath on a specified date in October 2012, however, this was not indicated on the bath record. Documentation was confirmed by the ADOC.
c) The care plan for resident #016 indicated that the resident was to have a tub bath on Wednesdays and Saturdays – and also indicated bed bath. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a tub bath on specified dates in October 2012. Documentation was confirmed by the ADOC.
d) The care plan for resident #011 indicated that the resident was to have bathing provided Mondays and Wednesdays. The PSW documentation record for October 2012 for bathing indicated that the resident was not provide with a bath on specified dates in October 2012 Documentation was confirmed by the ADOC.

Interview with PSW staff on November 28, 2012 confirmed that residents did not always receive two baths/week. [s. 33. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The policy for Hydration Management V9-251 indicated that all residents will be offered a minimum of 16 servings (2000 ml) of fluid daily as provided by the home's menu at meals and snack pass unless otherwise indicated on his/her plan of care. Total fluid intake for each resident will be tallied every 24 hours by Nursing staff and registered staff will be notified if a resident has not consumed at least 12 servings (75%) of the fluid provided at meals and snack by the homes' menu for 3 consecutive days. Upon notification, the Registered Nurse will review the care plan to determine if the resident has individualized daily fluid goals and if so assess if the resident is meeting his/her individualized goals. If the resident is not meeting individualized fluid goals or does not have individualized fluid goals indicated on the careplan, the Registered Nurse will initiate a hydration program as outlined in either A or B as follows. The timing of a referral to the Registered Dietitian will be made based on a nutritional risk level as well as risk for dehydration as assessed by Nursing. Nursing interventions to increase fluid intake will be initiated immediately. An immediate referral to the RD will be made for residents at high risk for dehydration. Residents at moderate or low risk will be referred to the RD if Nursing interventions are unsuccessful after a 3 day monitoring period.
A. Hydration Management Program for Residents at High Risk for Dehydration (these residents include those at high nutritional risk as per nutrition care plan, residents with skin ulcers, residents on thickened fluids, residents with recurrent UTI's, residents receiving a diuretic, residents with a history of dehydration, residents with fever, diarrhea, vomiting, residents receiving hypodermoclysis). Registered Nursing staff complete a Dietitian referral using the Dietitian referral form and implement Nursing interventions as follows: 1) Registered Nursing staff monitor resident's vital signs and monitor for clinical signs/symptoms of dehydration each shift and document in progress notes. Clinical signs/symptoms of dehydration include: fever, headache, dry mucous membranes, cracked lips, sunken eyes, decreased salivation, weakness, dark urine, < 800mls of urinary output in a day, increased heartbeat, low blood pressure, poor skin turgor, skin breakdown, severe constipation, rapid weight loss. If any clinical signs/symptoms of dehydration are noted, the physician will be notified immediately. Nursing staff will continue to monitor for signs and symptoms of dehydration and document each shift until resident's daily total fluid intake increases to 12 servings or more for 3 consecutive days unless directed otherwise by Physician. 2) Registered staff check the nutrition care plan to verify any favourite fluids recorded under likes/dislikes section and any interventions currently in place to optimize fluid intake 3) Registered Nursing staff notify resident/SDM of decrease in fluid intake and ask for input/update regarding favourite fluids and ask SDM for co-

operation/assistance in pushing fluids when visiting resident. 4) Registered Nursing staff communicate need to increase fluids to PSW staff who will offer/encourage intake of favourite fluids at meals, snack pass and during daily care 5) Registered Nursing staff will communicate any updated resident fluid preferences to Dietary by completing the diet requisition form. The FSM will update all pertinent dietary lists and the likes/dislikes section of the nutritional care plan as necessary 6) Registered Nursing staff will encourage additional fluids at medication pass 7) Nursing staff will offer fluids to resident during the night if resident awakens 8) Nursing will document outcome of nursing interventions in the progress notes and update the nursing care plan with new interventions 9) Registered staff will ask the attending physician or delegate to do a medical review for any medication such as diuretics that may need to be held until resident has adequate fluid intake 10) Registered staff will update Physician as needed.

Hydration Management Program for Residents as Lower Risk for Dehydration (low/moderate risk residents without additional risk factors related to dehydration). Nursing staff implement the following interventions and monitor the effectiveness of the interventions for the next 3 days: 1) Registered Nursing staff monitor resident's vital signs and monitor for clinical signs/symptoms of dehydration each shift and document in progress notes. Clinical signs/symptoms of dehydration include: fever, headache, dry mucous membranes, cracked lips, sunken eyes, decreased salivation, weakness, dark urine, < 800mls of urinary output in a day, increased heartbeat, low blood pressure, poor skin turgor, skin breakdown, severe constipation, rapid weight loss. If any clinical signs/symptoms of dehydration are noted, the physician will be notified immediately. 2) Registered staff check the nutrition care plan to verify any favourite fluids recorded under likes/dislikes section and any interventions currently in place to optimize fluid intake 3) Registered Nursing staff notify resident/SDM of decrease in fluid intake and ask for input/update regarding favourite fluids and ask SDM for co-operation/assistance in pushing fluids when visiting resident. 4) Registered Nursing staff communicate need to increase fluids to PSW staff who will offer/encourage intake of favourite fluids at meals, snack pass and during daily care 5) Registered Nursing staff will encourage additional fluids at medication pass 6) Nursing staff will offer fluids to resident during the night if resident awakens 7) Registered Nursing staff will communicate any updated resident fluid preferences to Dietary by completing the diet requisition form. The FSM will update all pertinent dietary lists and the likes/dislikes section of the nutritional care plan as necessary 8) Nursing will document outcome of nursing interventions in the progress notes and update the nursing care plan with new interventions 9) Registered staff will ask the attending

physician or delegate to do a medical review for any medication such as diuretics that may need to be held until resident has adequate fluid intake 10) Registered staff will update Physician as needed 11) If the resident increases daily fluid intake to 12 servings or more with nursing interventions during the 3 day monitoring period then the hydratioin program is successful and Registered Nursing staff can discontinue monitoring vital signs and for signs and symptoms of dehydration. A referral to the Registered Dietitian is not necessary 12) If the resident continues to drink less than 12 servings for the 3 day monitoring period with nursing interventions, then the Registered Nurse will complete a referral to the Registered Dietitian.

a) The plan of care for resident 015 indicated that the resident required 1750-2100 ml fluid/day. The resident was assessed to be at High Nutritional risk and had recurrent urinary tract infections. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements on specified dates in September and October 2012. Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.

b) The plan of care for resident 006 indicated that the resident required 1400-1700 ml fluid/day. The resident was assessed to be at High Nutritional risk. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements on specified dates in September and October 2012. Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.

c) The plan of care for resident 007 indicated that the resident required 1900-2300 ml fluid/day. The resident was assessed at High Nutritional risk. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements on specified dates in September and October 2012. Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.

d) The plan of care for resident 002 indicated that the resident required 1900-2200 ml fluid/day. The resident was assessed at High Nutritional and hydration risk. A review of the Hydration Intake Record for September, October and November 2012 indicated

that the resident was below fluid requirements on specified dates in September, October and November 2012 (29 consecutive days). Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above. [s. 8. (1)]

2. The Diabetes Management – Blood Glucose Monitoring Policy V3-450 indicates that the registered nursing staff will document the results on the individual resident's blood glucose monitoring record. It was noted that the home uses two different Resident Blood Glucose Monitoring forms.
The Diabetes Management – Hypoglycemia Policy V3-453 indicates that when blood glucose level drops below 4 mmol/L, or if the resident demonstrates symptoms of hypoglycemia, the following steps will be taken by the registered nursing staff, provided the resident can swallow. Step A Treatment of Mild to Moderate Hypoglycemia (Conscious): 15 grams carbohydrate: 3 glucose tablets (preferred) or 3 teaspoons or 3 packets of table sugar dissolved in water (preferred) or ¾ cup of juice or regular soft drink or 1 tablespoon of honey. Step B: Wait 15 minutes and re-test blood glucose, retreat with another 15 grams of carbohydrate if blood glucose level remains under 4 mmol/L. Source of 15 grams of carbohydrate may include: 175 ml juice or soft drink, 3 tablespoons (15ml) or 3 packets of white sugar. For diabetic residents requiring thickened fluids, the home will ensure that the appropriate consistency of juice is readily available 24 hours per day on each home area. Once blood glucose has returned to above or equal to 4.0 mmol/L, the resident should have the usual meal or snack that is due at that time of day. If the time of the next meal/snack is greater than one hour away, give the resident one of the following snacks: snacks should include 15 grams carbohydrate with a protein source: 6 crackers and 1 oz cheese or 15 ml peanut butter or 2/3 cup (150ml) of milk or ½ sandwich or bowl of cereal with milk or 125 ml of boost supplement or 175ml pudding or yogurt. *Notify physician of the hypoglycemic reaction. Provide the resident and or substitute decision maker with a status update. Document all assessments, interventions and outcomes as appropriate in the clinical record.
The policy does not indicate to hold insulin and the home does not have a policy on holding insulin.
a) The blood glucose monitoring form for resident 003 indicated a blood glucose reading of 3.2 mmol/L in October 2012 before supper. It was retested an hour later not fifteen minutes later as the policy indicates. Documentation was not provided to

indicate that the physician had been notified of the hypoglycemic episode.
On another date in October 2012 progress notes indicated that the residents' blood glucose was 4.5 mmol/L before breakfast and insulin was held. Documentation was not provided to indicate that the physician had ordered the insulin to be held. Notes indicated that blood glucose before lunch was 3.4 mmol/L, insulin was held and the resident was given orange juice. Documentation did not indicate that the resident's blood glucose was tested again after fifteen minutes. At 1:30pm, blood glucose was 7.4 mmol/L and insulin was still held. Documentation was not provided to indicate that the physician had ordered the insulin to be held. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
On another date in October 2012 progress notes indicated that the resident was unresponsive and had a blood glucose reading of 2.6 mmol/L at 11:45 am, 2.9 mmol/L at 12:20pm, 2.6 mmol/L at 12:45pm, 3.2 mmol/L at 1:00pm, and 5.4 mmol/L at 2:00pm. These readings were not found on the Blood Glucose Monitoring sheet except for 5.4 mmol/L at 2:00pm.
The blood glucose monitoring form indicated a blood glucose reading of 3.3 mmol/L on another date in October 2012 before supper. The resident's blood glucose was retested again half hour later not fifteen minutes as the policy indicates.
Documentation was not provided to indicate that the physician had been notified of the hypoglyemic episode as the policy indicates.
The blood glucose monitoring form indicated a blood glucose reading of 3.2 mmol/L on another date in October 2012 before breakfast. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
On another date in October 2012 progress notes indicated that the resident had a blood glucose reading of 3.5 mmol/L, however, this was not noted on the Blood Glucose Monitoring sheet. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The blood glucose monitoring form indicated a blood glucose reading of 3.7 mmol/L on another date in October 2012 before breakfast. The resident's blood glucose was retested again an hour and a half hour later not fifteen minutes as the policy indicates.
Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The blood glucose monitoring form indicated a blood glucose reading of 3.9 mmol/L on another date in October 2012 before breakfast. The resident's blood glucose was retested again an hour and fifteen minutes later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.

The blood glucose monitoring form indicated a blood glucose reading of 3.1 mmol/L on another date in October 2012 before breakfast. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The ADOC confirmed that the blood glucose was not checked after fifteen minutes or physician notified as per policy.
b) The blood glucose monitoring form for resident 001 indicated a blood glucose reading of 3.9 mmol/L in November 2012 before lunch, however, there was no documentation to indicate that it had been retested (fifteen minutes later) as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode as the policy indicates. The ADOC confirmed that the blood glucose was not checked after fifteen minutes or physician notified as per policy.
c) The blood glucose monitoring form for resident 003 indicated a blood glucose reading of 3.2 mmol/L in October 2012 before supper. It was retested an hour later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode as the policy indicates. The ADOC confirmed that the blood glucose was not checked after fifteen minutes or physician notified as per policy. [s. 8. (1)]

3. Policy V3-240 Continence bowel-bowel routine policy and V3-880.1 Medical Directives were not followed. According to the policy, the registered staff will update the resident's care plan. The Director of Care will collaborate with the Medical Advisor to establish a bowel routine, approved for use by the Medical Advisor of the Home. Bowel routine will be reviewed and signed by homes Medical Director for each individual resident, as required. The Medical Directives policy for constipation indicated if no BM (bowel movement) for 2 days, give Colace 100 mg three times/day and Senekot 1-2 tabs at bedtime. If no BM for 3 days give Lactulose 1-2 tsp four times/day, if no results give suppository or enema, if still no results, repeat Lactulose the next day. Notify Physician if no BM x 6 days.
a) Resident 007 did not have a BM for six consecutive days in October 2012, however, according to the MARS (Medication Administration Record), the resident was not given Colace or Senekot and received Lactulose once/day on specified dates in 2012. There was no indication that the physician had been notified.
b) Resident 011 did not have a BM for six consecutive days in October 2012, however, according to the MARS, the resident was not given Colace or Senekot and received Lactulose on a specified date in October 2012. There was no indication that the physician had been notified. [s. 8. (1)]

4. The policy for Lost/Missing clothing V8-300 indicated that the Environmental Services Manger or designate will set up an area in the home for residents/resident's representatives to view lost clothing and collect back clothing that cannot be identified by home staff. Upon investigation on November 7, 2012, it was noted that there was not an area in the Laundry room for missing items and the inspector was told that the lost and found was set up in the lounge. When shown the area, the cabinet was behind several lifts and was locked. The inspector was told by the staff member that the key had been lost and they required Maintenance to unscrew the lock in order to open the cabinet door and therefore was inaccessible.
The policy also stated that the Director of Administration or designate will contact the family to advise of the outcome and sign the competed Lost/Missing item report. The only form provided to the inspector was one dated August 17, 2012 which outlined several pairs of missing socks. The section indicated that the items were found, was checked off, however, the remainder of the form including date, location item found, send to laundry for labelling, notify resident or POA and resident satisfaction was not completed. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 131. (2)	CO #004	2011_061129_0006	167
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2011_061129_0006	156

LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #007	2011_061129_0006	156
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #008	2011_061129_0006	156

Issued on this 4th day of February, 2013

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

Carol Polcz, RD Marilyn Tone

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), MARILYN TONE (167)
Inspection No. / No de l'inspection :	2012_122156_0024
Log No. / Registre no:	H-002114-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 9, 2013
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRANTFORD 389 WEST STREET, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LINDA PRINCE

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:

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2011_061129_0006, CO #006;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that there is a written plan of care for residents 001, 007 and 006 that sets out clear directions to staff and others who provide direct care including directions for nutritional care.
The licensee shall prepare, submit and implement a plan to ensure that there is a written plan of care for all residents that sets out clear directions to staff and others who provide direct care including directions for nutritional care.
The plan should be submitted via email by January 31, 2013 to Carol Polcz at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7
HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. Previously identified as non compliant August 2011 and issued as an Order. The plan of care did not provide clear directions to staff providing care with respect to the following:
a) The plan of care for resident 007 provided conflicting directions to staff with respect to diet. The resident had a diet order change in October 2012 to regular texture, however the care plan indicated the resident required a minced texture. One area of the care plan indicated that the resident was at moderate nutritional risk, however, another area indicated high nutritional risk.
b) The plan of care for resident 001 provided conflicting directions to staff with respect to diet. The resident had a diet order for NPO (nothing by mouth), however, the care plan indicated registered staff to monitor for changes in blood glucose and if necessary provide a specified treatment. The care plan did not provide specific information related to the administration of this treatment.
c) The plan of care for resident 006 provided conflicting directions to staff with respect to diet. The care plan indicated 235ml Ensure Plus at AM and PM snacks as well 250 cc chocolate milk at HS snack, however, the most current RAP (resident assessment protocol) dated October 11, 2012 indicated that these were discontinued. The care plan also indicated a goal to gain weight, however, the RAP indicated that this was no longer realistic and that weight maintenance was the goal.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2011_061129_0006, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The Licensee shall ensure that staff bath residents 007, 006, 016, and 011 at minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. The Licensee shall ensure there are adequate staff available to meet the bathing needs of the residents.
The licensee shall prepare, submit and implement a plan to ensure that staff bath each resident at minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. The Licensee shall ensure there are adequate staff available to meet the bathing needs of the residents.
The plan should be submitted via email by January 31, 2013 to Carol Polcz at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. Previously identified as non compliant August 2011 and issued as an Order. Records documenting the care provided to residents for October 2012 were reviewed and resident's did not consistency receive two baths per week.
a) The plan of care for resident 007 indicated that the resident was to have a shower on Tuesdays and Fridays – the resident prefers a shower but will have a bath. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a tub bath or a shower on specified dates in October 2012.
b) The plan of care for resident 006 indicated that the resident was to have a shower Wednesdays and Fridays. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a shower (or tub bath) on specified dates in October 2012. The progress notes indicated that the resident received a bed bath on a specifed date in October 2012, however, this was not indicated on the PSW documentation bath record.
c) The plan of care for resident 016 indicated that the resident was to have a tub bath on Wednesdays and Saturdays – also indicated bed bath. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with a tub bath on specified dates in October 2012.
d) The plan of care for resident 011 indicated that the resident was to have bathing provided Mondays and Wednesdays. The PSW documentation record for October 2012 for bathing indicated that the resident was not provided with bathing on specified dates in October 2012
All documentation was confirmed by the ADOC. Several PSW staff were interviewed and confirmed that resident's do not always receive two baths/week and that often there is not enough staff to provide two baths per week.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2013

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2011_061129_0006, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 shall ensure that residents 020 and 011 are reassessed and plans of care revised when care needs change. The licensee shall prepare, submit and implement a plan to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. The plan shall include a) assessment of current method for revising and updating the care plan when care needs change b) staff education to be completed and dates of the education c) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance. The plan should be submitted via email by January 31, 2013 to Carol Polcz at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. Previously identified as non compliant August 2011 and issued as an Order. Residents were not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary.

2. Resident # 020 experienced a change in condition in October 2012 and was

transferred to hospital. Upon return from hospital, the care plan was not updated to include the resident's risk for the change in condition nor were there any interventions identified to direct staff related to monitoring activities or how to respond if such a change should occur. (167)

2. The plan of care for resident # 011 was not reviewed and revised when the resident's care needs changed.
a) In October 2012, resident # 011 was noted to have suffered a change in condition. The resident's Power of Attorney (POA) requested that the resident be kept in bed and requested that the resident be kept comfortable. The resident's physician prescribed a narcotic medication to be administered subcutaneously via a butterfly to maintain the resident's comfort. The document that the home refers to as the care plan was not updated to include these interventions or the change in the resident's condition.
b) In October 2012 the progress notes for resident # 011 indicate that the resident had developed a pressure area. The care plan was not updated to include this area of skin breakdown until later in November 2012.
c) In November 2012, the resident's condition deteriorated further and the resident was deemed by the physician with input from the POA to be palliative. The care plan for the resident was not reviewed and revised to include the resident's palliative status or their current needs with regards to care until later in November 2012. The care plan was not revised to include the changes in the resident's care needs related to activities of daily living (toileting, hygiene and grooming, eating) or the changes to the resident's behavioural care plan that were no longer applicable.
d) The nutritional care plan for resident # 011 was noted to be last reviewed in August 2012 and did not include current interventions with regards to their nutritional needs or palliative status. The nutritional care plan still indicated that the resident uses a plate guard stabilizer and built-up utensils, a lipped plate at meals, that he/she could eat by his/herself as long as they are set up and that there was a need to discourage the resident from snacking on sandwiches at night and eating extra desserts. The resident currently is receiving assistance from a specified nurse to feed at breakfast, lunch and supper. Staff interviewed confirmed that the resident is no longer able to feed him/herself and requires total assistance to eat meals. This information is not included in the resident's care plan. (167)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2013

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2011_061129_0006, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the following policies for bowel routine protocol, diabetes management, hydration, and missing clothing are complied with. The plan shall include a) staff education to be completed and dates of the education b) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance. The plan shall be submitted via email by January 31, 2013 to Carol Polcz at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. Previously identified as non compliant August 2011 and issued as an Order. Policy V3-240 Continence bowel-bowel routine policy and V3-880.1 Medical Directives were not followed. According to the policy if no BM for 2 days, give Colace 100 mg three times/day and Senekot 1-2 tabs at bedtime. If no BM for 3 days give Lactulose 1-2 tsp four times/day, if no results give suppository or enema, if still no results, repeat Lactulose the next day. Notify Physician if no BM x 6 days.
a) Resident 007 did not have a BM for six consecutive days in October 2012, however, according to the MARS, the resident was not given Colace or Senekot and received Lactulose once/day on three dates in October 2012. There was no

indication that the physician had been notified.
b) Resident 011 did not have a BM for six consecutive days in October 2012, however, according to the MARS, the resident was not given Colace or Senekot and Lactulose was not given until a specified date in October 2012. There was no indication that the physician had been notified.
(156)

2. The Diabetes Management – Blood Glucose Monitoring Policy V3-450 and Hypoglycemia Policy V3-453 were not followed. According to the policies, the registered nursing staff will document the results on the individual resident's blood glucose monitoring record. The home uses two different Resident Blood Glucose Monitoring forms. When blood glucose levels drop below 4 mmol/L, or if the resident demonstrates symptoms of hypoglycemia, several steps were to be followed and the physician was to be notified of the hypoglycemic episode. The home does not have a policy on orders for holding insulin.
a) The blood glucose monitoring form for resident 003 indicated a blood glucose reading of 3.2 mmol/L in October 2012 and was retested an hour later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode. On another date in October 2012 progress notes indicated that the residents' blood glucose was 4.5 mmol/L before breakfast and insulin was held. Documentation did not indicate that the physician had ordered the insulin to be held. Notes indicated that blood glucose before lunch was 3.4 mmol/L, insulin was held and the resident was given orange juice. Documentation did not indicate that the resident's blood glucose was tested again after fifteen minutes. At 1:30pm, blood glucose was 7.4 mmol/L and insulin was still held. Documentation was not provided to indicate that the physician had ordered the insulin to be held or that the physician had been notified of the hypoglycemic episode.
On another date in October 2012 progress notes indicated that the resident was unresponsive and had a blood glucose reading of 2.6 mmol/L at 11:45 am, 2.9 mmol/L at 12:20pm, 2.6 mmol/L at 12:45pm, 3.2 mmol/L at 1:00pm, and 5.4 mmol/L at 2:00pm. These readings were not found on the Blood Glucose Monitoring sheet except for the 5.4 mmol/L at 2:00pm. The blood glucose monitoring form indicated a blood glucose reading of 3.3 mmol/L on another date in October 2012. The resident's blood glucose was retested again half hour later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode as the policy indicates.

The blood glucose monitoring form indicated a blood glucose reading of 3.2 mmol/L on another date in October 2012 Documentation was not provided to indicate that the physician had been notified of the hypoglycaemic episode.
On another date in October 2012 progress notes indicated that the resident had a blood glucose reading of 3.5 mmol/L however, this was not noted on the Blood Glucose Monitoring sheet. Documentation did not show that the physician had been notified of the hypoglycemic episode.
The blood glucose monitoring form indicated a blood glucose reading of 3.7 mmol/L on another date in October 2012. The resident's blood glucose was retested again an hour and a half hour later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The blood glucose monitoring form indicated a blood glucose reading of 3.9 mmol/L on another date in October 2012. The resident's blood glucose was retested again an hour and fifteen minutes later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The blood glucose monitoring form indicated a blood glucose reading of 3.1 mmol/L on another date in October 2012 before breakfast. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
The Assistant Director of Care confirmed that the blood glucose was not retested after fifteen minutes, the physician had ordered insulin to be held or been notified of each hypoglycemic episode.
b) The blood glucose monitoring form for resident 001 indicated a blood glucose reading of 3.9 mmol/L in November 2012, however, it was not retested fifteen minutes later as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode.
c) The blood glucose monitoring form for resident 003 indicated a blood glucose reading of 3.2 mmol/L in October 2012. It was retested an hour later not fifteen minutes as the policy indicates. Documentation was not provided to indicate that the physician had been notified of the hypoglycemic episode as the policy indicates.

(156)

3. The policy for Hydration Management V9-251 was not followed. The policy indicated that all residents will be offered a minimum of 16 servings (2000 ml) of

fluid daily unless otherwise indicated on his/her plan of care. Total fluid intake for each resident will be tallied and registered staff will be notified if a resident has not consumed at least 12 servings (75%) of the fluid provided at meals and snack by the homes' menu for 3 consecutive days. The Registered Nurse will review the care plan to determine if the resident has individualized daily fluid goals and if so assess if the resident is meeting his/her individualized goals. If the resident is not meeting individualized fluid goals or does not have individualized fluid goals indicated on the care plan, the Registered Nurse will initiate a hydration program as outlined in the policy. The timing of a referral to the Registered Dietitian will be made based on a nutritional risk level as well as risk for dehydration as assessed by Nursing. Nursing interventions to increase fluid intake will be initiated immediately. An immediate referral to the RD will be made for residents at high risk for dehydration. Residents at moderate or low risk will be referred to the RD if Nursing interventions are unsuccessful after a 3 day monitoring period.
a) The plan of care for resident 015 indicated that the resident required 1750-2100 ml fluid/day. The resident was assessed to be at High Nutritional risk and had recurrent urinary tract infections. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements from September 1-3, 2012 (3 consecutive days), from September 10-23, 2012 (13 consecutive days), from September 26-28, 2012 (3 consecutive days) and October 17-21 (4 consecutive days). Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.
b) The plan of care for resident 006 indicated that the resident required 1400-1700 ml fluid/day. The resident was assessed to be at High Nutritional risk. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements from September 1-11, 2012 (10 consecutive days), from September 24-27, 2012 (3 consecutive days), October 6-10, 2012 (4 consecutive days), October 13-16, 2012 (3 consecutive days), October 26-30, 2012 (4 consecutive days). Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.
c) The plan of care for resident 007 indicated that the resident required 1900-

2300 ml fluid/day. The resident was assessed at High Nutritional risk. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements from September 1-4, 2012 (3 consecutive days), September 10-22, 2012 (12 consecutive days), September 24-30, 2012 (6 consecutive days), October 12-16 (4 consecutive days), and October 18-21 (3 consecutive days).
Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above.
d) The plan of care for resident 002 indicated that the resident required 1900-2200 ml fluid/day. The resident was assessed at High Nutritional and hydration risk. A review of the Hydration Intake Record for September and October 2012 indicated that the resident was below fluid requirements from September 10-14, 2012 (4 consecutive days), October 5-November 3, 2012 (29 consecutive days).
Progress notes did not indicate that Registered Nursing staff completed a Dietitian referral using the Dietitian referral form or implement Nursing interventions as outlined in the policy. The Registered Dietitian confirmed that a referral was not made for the resident on any of the occasions as noted above. (156)

4. The policy for Lost/Missing clothing V8-300 was not followed. The policy indicated that there will be an area in the home for residents/resident's representatives to view lost clothing and collect back clothing that cannot be identified by home staff. Upon investigation on November 7, 2012, it was noted that there was not an area in the Laundry room for missing items and the inspector was told that the lost and found was set up in the lounge. When shown the area, the cabinet was behind several lifts and was locked. The inspector was told by the staff member that the key had been lost and they required Maintenance to unscrew the lock in order to open the cabinet door and therefore was inaccessible.
The policy also stated that the Director of Administration or designate will contact the family to advise of the outcome and sign the competed Lost/Missing item report. The only form provided to the inspector was one dated August 17, 2012 which outlined several pairs of missing socks. The section indicated that the items were found, was checked off, however, the remainder of the form including date, location item found, send to laundry for labelling, notify resident or POA and resident satisfaction was not completed as per policy. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 9th day of January, 2013

Signature of Inspector / Signature de l'inspecteur : Carol Polcz, RN

Name of Inspector / Nom de l'inspecteur : CAROL POLCZ

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