Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 4, 2017	2017_578672_0011	009555-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

MAPLEWOOD
12 MAPLEWOOD AVENUE BOX 249 BRIGHTON ON K0K 1H0

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

JENNIFER BATTEN (672), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 5, 6, 7, 8, 9, 12, 13, and 14, 2017.

Critical Incident Report (CIR) (Log#001349-17), related to allegations of resident to resident abuse.

Critical Incident Report (CIR)(Log#004209-17), related to an unexpected resident death.

Critical Incident Report (CIR) (Log#008974-17), related to allegations of improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), RAI/Clinical Care Coordinator (CCC), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Registered Dietician (RD), Housekeeping/Laundry Aides, Physiotherapy Assistant (PTA), resident's council president, residents and their family members.

Also during the course of this inspection, the inspectors toured the home, observed medication administration, infection control practices, staff to resident interactions, resident to resident interactions, reviewed resident clinical health records, medication incident documentation, the Family and Resident Council meeting minutes, applicable policies and procedures, and the licensee's investigations documentation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed, and his or her bed system evaluated in accordance with evidence based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as "useful resources", and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings´ (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is

recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident's right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Resident #006 was observed by Inspector #672 to have bilateral quarter rails positioned in the middle of the bed, in the engaged position when the resident was in the bed. Clinical health records for resident #006 were reviewed, and identified the resident as being at high risk for falls, and that the bed rails were required and utilized to assist with bed mobility and repositioning.

During an interview on a specified date with Inspector #672, resident #006 indicated the bed rails were utilized for bed mobility and repositioning during personal care.

Inspector #672 interviewed PSW#113 on a specified date, regarding resident #006's usage of the bed rails. PSW#113 indicated that resident #006 does utilize the bed rails during completion of personal care, and to assist with bed mobility and repositioning.

Through an interview with the Administrator on a specified date, Inspector #672 was informed that the Environmental Service Manager (ESM) and Director of Care (DOC) were working together to complete the Side Rail Use Assessment Form for all of the residents in the home currently utilizing bed rails. On June 12, 2017, a package was provided to Inspector #672 reviewing which residents were outstanding for having the assessment completed. Review of the package provided revealed that eleven of the home's forty-nine residents currently had bed rails on their beds, and these have not been assessed for the safe use of the bed rails.

On a specified date, during an interview with Inspector #672, the DOC indicated that where bed rails are being used, the residents have not been assessed, and the bed

system evaluated in accordance with evidence based practices. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an interview on June 7, 2017 with the Environment Services Manager (ESM), Inspector #672 was informed that a bed entrapment audit had been completed in the home in July 2016, and there were several resident beds in use, with failed entrapment zones.

Review of the licensee's current bed system evaluation was conducted by Inspector #672. The bed entrapment audit indicated that eleven out of the forty-nine beds in the home failed one or more entrapment zones. During an interview on June 8, 2017, the Administrator indicated to Inspector #672 that the home purchased new equipment last year, including beds, and there was a goal to purchase more, on an ongoing annual basis, as the budget allowed, to replace the systems which have failed. The Administrator also informed Inspector #672 that the ESM and DOC were working together to assess all residents for entrapment risks, with interventions to be put in place to ensure their safety, should they currently be in a bed with one or more failed zones.

During an interview on June 15, 2017 with Inspector #672, the DOC indicated that the home currently had eleven residents actively using bed systems with one or more failed entrapment zones, and no interventions or accessories had been implemented to reduce the risk of entrapment for these eleven residents. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #018's plan of care related to transferring was provided to the resident as specified in the plan.

Related to log #008974-17:

Inspector #601 reviewed a Critical Incident Report (CIR) and the licensee's internal investigation notes. The licensee's internal investigation notes indicated that on a specified date at a specified time, RN #116 was approached by resident #018 to assess blood noted on the resident's sleeve. RN #116 documented in the incident report that resident #018 had a skin tear and the resident did not recall hitting the area. According to the CIR, resident #018 reported to RN #116 that the skin tear was acquired early in the day when the student nurse had dropped the resident on the floor during a transfer.

The CIR indicated that on a specified date at a specified time, RPN Student #110 was assisting resident #018 to transfer. The licensee's internal investigation included a written statement of the incident according to RPN Student #110. RPN Student #110 indicated that she had forgotten to check resident #018's mobility status and had her hand on the back of resident #018 to guide the resident into bed. Resident #018 started to fall as the resident was turning around to sit on the bed. The RPN Student #110 statement indicated that resident #018 grabbed the side rail and RPN student #110 wrapped her arms around the resident's waist to prevent the resident from falling. RPN Student #110's written statement indicated that the resident denied injury at the time of the incident.

Review of resident #018's current transferring care plan interventions in place at the time of the incident indicated that the resident required a specified level of assistance from a set number of staff members.

During an interview on June 9, 2017 at approximately 1150 hour, RN #104 indicated to Inspector #601 that all residents have a logo located on the head board of their bed to communicate transfer status to staff. At this time, RN #104 pointed out the transfer logo

located on the head board of resident #018's bed to Inspector #601.

During an interview on June 9, 2017 at approximately 1055 hour, HCA #111 indicated that resident #018 required assistance with transfers, but was able to assist with transfers.

During an interview on June 9, 2017 at approximately 1150 hour, PSW #112 indicated that resident #018 was able to assist with transfers. PSW #112 indicated to Inspector #601 that resident #018 was no longer being transferred using a specified transfer technique.

During an interview on June 9, 2017 at approximately 1150 hour, RN #104 indicated to Inspector #601 that she was not aware that staff were not using the specified transfer method when transferring resident #018. RN #104 also indicated that staff should be using the specified transfer method for all transfers as specified in resident #018's plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in resident #018's plan of care related to transferring is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O.Reg. s. 114 (2), the home is to have written policies and protocols developed for the Medication Management System to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Oxygen is considered to be a medication as per Health Canada. A medication includes any substance or mixture of substances manufactured, sold or represented for use in:
(a) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or its symptoms, in human beings or animals,
(b) restoring, correcting or modifying organic functions in human beings or animals

While Inspector #601 and #672 were in the home, resident #030 was observed on a daily basis, and was noted to be utilizing oxygen. On June 12, 2017, Inspector #601 observed resident #030 to be quite short of breathe, with some pallor. Assistance was requested from the nursing staff in the home, and PSW#100 arrived to assist resident #030.

Review of resident #030's Physician Medication Review by Inspector #672 revealed that resident #030 has an order for oxygen as required.

Interview with PSW#100 was completed following the incident on June 12, 2017. PSW#100 indicated that resident #030 has a behavior, where the resident touches the dial on the oxygen canister on their own, and will turn the flow of oxygen up or down, depending on how the resident is feeling, without reporting this to the staff of the home.

Interview completed with RN#104 by Inspector #672 on June 12, 2017, where RN#104 indicated resident #030 did indeed have those behaviors, and frequently was noted to be utilizing the oxygen at levels not according to the doctor's orders. RN#104 also acknowledged that resident #030 currently uses the oxygen on a daily basis.

Review of resident #030's June 2017 eMAR revealed that resident #030 does have an order listed for oxygen as required, but no signatures were present on the eMAR system, to indicate that resident #030 was using the oxygen at all.

Inspector #672 interviewed RN#104 on June 12, 2017, where RN#104 indicated that resident #030 does have a medical order for oxygen to be used as required, but that she does not go into the eMAR system to sign off that the resident is using the oxygen. RN#104 indicated that it is the expectation of the Registered Staff to sign the eMAR after administering a prn medication, along with follow up documentation on the effectiveness of the prn given, within an hour of administration.

Inspector #672 interviewed the DOC, where the DOC indicated that it is the expectation of the licensee that the Registered Staff administer medications according to the medication administration standards supported through the College of Nurses of Ontario, which are reflected in the licensee's policies and procedures regarding medication administration, in the Pharmacy Policy and Procedure Manual for LTC Homes.

Inspector #672 reviewed the licensee's Pharmacy Policy and Procedure Manual for LTC Homes, Section 8-Documentation and Record Keeping; Policy 8-4, PRN Administration and Documentation, dated February 2017, which stated the following:

Policy – To ensure that PRN (as needed) medications are administered appropriately and all documentation is completed.

Procedure –
3. Administer the medication to the resident and observe for effect
4. Document administration on MAR sheet including:
 * Time of administration
 * Actual dose given for orders with dosage ranges
 * Initial in correct date column
5. Document nursing assessment and follow-up on Progress Notes, facility PRN Administration Record or on reverse side of the MAR sheet, according to the facility's

practice. Documentation to include:
* date, time, medication, dose, reason (as applicable to physician's order) medication was given, nurse's initials.
* effect, nurse's initials
7. For PRN medications given on a routine basis, ask the physician to consider changing the order to a routine order.

Policy 8-1, from Section 8 – Documentation and Record Keeping of the licensee's Pharmacy Policy and Procedure Manual for LTC Homes, dated February 2017, entitled "Medication Administration Record (MAR/TAR), stated the following:

Medication Administration Record;
1. Chart all medication administered by signing your initials in the appropriate box corresponding to correct medication, date, and time on the MAR sheet.
3. Failure to chart a medication that has been given or not given is considered a medication incident and must be reported.

Nurse;
6. Charting in progress notes is required for PRN medication use and topical treatments evaluation effectiveness.

Both the DOC and RN#104 acknowledged that the policies were not being followed, as none of the Registered Staff in the home were signing for the administration of oxygen to resident #030, when it was required, nor the effectiveness. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on an assessment, and that the plan is implemented.

During review of two medication incident reports which involved resident #026, Inspector #672 reviewed resident #026's progress notes. Review of progress notes revealed a notation on a specified date from the DOC, which stated that resident #026's spouse was concerned about resident #026's quality of life, as the resident had been suffering from diarrhea quite frequently over the last few weeks. Following an investigation completed by the DOC, it was noted that resident #026 had experienced a specified number of episodes of diarrhea on a specified number of days, three of which were a result of a laxative medication, as per resident #026's bowel protocol.

Inspector #672 reviewed resident #026's Physician Medication Review, which revealed resident #026 has a personalized bowel protocol.

Inspector #672 reviewed the Point of Care (POC) flow sheets for resident #026 for a one month period, which revealed that resident #026 was a candidate to receive a specified treatment, on "day two" without a bowel movement, as per the bowel routine, on sixteen occasions during the one month period.

Inspector #672 reviewed resident #026's eMAR for the one month period, which revealed that resident #026 had received a specified treatment only once during that period, and another specified treatment on "day two" without a bowel movement five times during that time period. Resident #026 then experienced more days without a bowel movement, which lead to resident #026 receiving a laxative medication five times during the same period, causing resident #026 to experience diarrhea.

The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on an assessment, and that the plan is implemented. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's personalized bowel protocol is followed, as per MD orders, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #023 and resident #024 by not implementing the identified interventions.

Related to log #001349-17:

On June 12, 2017, Inspector #601 reviewed the licensee's investigation documentation for a CIR submitted to the Director. The CIR indicated that on a specified date at a specified hour, the Administrator was having a conversation with resident #024 near the nurse's station. Resident #023 was walking down the hall towards the Administrator and resident #024. Resident #024 loudly asked the Administrator a negative question regarding resident #023. Resident #023 continued to walk towards the nurse's station. Resident #023 reached around the Administrator and grabbed resident #024's shirt collar while the Administrator was speaking to resident #024 about the comment made towards resident #023. Resident #023 also slapped resident #024 causing an injury. Resident

#024 also had sustained an injury. The Administrator and RN #106 immediately intervened to separate the two residents and resident #024 was noted to be weepy following the incident and couldn't understand why resident #023 would strike out.

According to the same CIR, residents #023 and #024 had a physical altercation on two occasions during the end of 2016.

Review of resident #023 and #024's progress notes during a six month period of time in 2017 indicated that there was a physical altercation between resident #023 and #024 on five dates during that time period. Resident #024 was noted to have responsive behaviours. Resident #023 became angry with resident #024's responsive behaviours and reacted.

Review of resident #024's clinical health records identified that a behaviour sheet to track incidents of anger or distress had not been completed during the six month period of time.

Review of resident #023 and #024's clinical health records identified that on two of the dates in 2017, there was no documentation indicating the care planned interventions for security checks had been completed for resident #023 and #024 prior to the physical altercation between the residents.

Review of resident #023 and #024's clinical health record identified that a behaviour tracking tool had not been initiated since January 2017 and the security checks were not documented as completed. The care plan at the time of the physical altercations did not identify the steps taken to minimize the risk of altercations and potentially harmful interactions between resident #023 and resident #024. The planned interventions for resident #024 were not implemented successfully, and steps were not always taken to minimize the risk for both residents resulting in five potentially harmful altercation between resident #023 and #024 during a six month period of time in 2017. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #023 and resident #024 by implementing the identified interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the licensee's medication incidents which occurred during a three month period of time in 2017 was conducted by Inspector #672. It was noted that eleven medication incidents occurred during this time period.

Resident #026 became ill on a specified date. Review of resident #026's Digital Prescriber's Orders sheet revealed an order for an antibiotic, which was to be completed within seven days.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred over a three day period of time. On a specified date, RPN#107 noted the antibiotic order was still showing on the eMAR system, and the medication continued to be administered to the resident, although the medication was due to have been completed.

Review of resident #026's eMAR revealed that the antibiotic was signed for and administered four times over a two day period. Resident #026 received four extra doses of the antibiotic, with no adverse effects noted.

Review of the Medication Incident Report and resident #026's progress notes revealed no documentation to support that the resident/SDM or MD were notified of the incident.

Interview with DOC indicated that DOC was unsure if the resident/SDM or MD had been notified of the medication incident, therefore DOC placed a call to resident #026's spouse, and informed them of the above incident. Resident #026's spouse could not recall being notified previously of the medication incident.

During a specified month of 2017, staff were beginning to notice that resident #026 was having increased pain in the mornings. Review of resident #026's Physician Medication Review revealed that the resident has an order for an analgesic three times per day, which were administered at set hours.

Review of resident #026's eMAR for a specified month revealed that on a specified date, staff began administering the morning dose of the analgesic two hours prior, to assist resident #026's pain during the morning.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred on that day. Review of the Medication Incident Report revealed that during a medication pass, RPN#107 noted there were multiple routine analgesic orders documented and available in the eMAR system. On the specified date, RPN#107 deleted the duplicate order from the eMAR system, to ensure resident #026 only received the analgesic as ordered. There were no adverse reaction noted to resident #026 as a result of the medication incident.

Review of the Medication Incident Report and resident #026's progress notes, revealed no documentation to support that the resident/SDM or MD were notified of the incident.

Interview with DOC indicated that DOC was unsure if the resident/SDM or MD had been notified of the medication incident, therefore DOC placed a call to resident #026's spouse, and informed them of the above incident. Resident #026's spouse could not recall being notified previously of the medication incident.

Resident #012 became ill on a specified date. Review of resident #012's Prescriber's Fax Order sheet revealed resident #012 was to receive an antibiotic, and the order was due to be completed within one week.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred over a two day period. On the specified date, RPN#107 noted the antibiotic was due to have been completed on a prior date, but was still showing on the eMAR system, and continued to be administered to the resident.

Review of resident #012's eMAR revealed that the antibiotic was signed for and administered over a two day period. Resident #012 received three extra doses of the antibiotic, with no adverse reaction noted to the resident.

Review of the Medication Incident Report and resident #012's progress notes revealed no documentation to support that the resident/SDM or MD were notified of the incident.

Interview with DOC indicated that DOC was unsure if the resident/SDM or MD had been

notified of the medication incident, therefore DOC placed a call to resident #012's SDM, and informed them of the above incident. Resident #012's SDM could not recall being notified previously of the medication incident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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

Review of the licensee's medication incidents which occurred between a three month period, was conducted by Inspector #672. It was noted that eleven medication incidents occurred during this time period.

Review of the eleven Medication Incident Reports, along with the licensee's Medication Error Summary for the three month period, revealed that the medication incidents and adverse drug reactions were documented, reviewed and analyzed, but no corrective actions had been taken as necessary.

Interview with the DOC by Inspector #672 was conducted, where the DOC indicated that she may have spoken to some of the staff members regarding some of the medication incidents, but could not recall any specifics of who was spoken to, regarding what medication incidents, nor when these conversations occurred. The DOC acknowledged there was no documentation to support that any conversations had taken place, nor that any corrective actions had been implemented in any of the eleven medication incidents, which occurred between a three month period of time in 2017.

The licensee has failed to ensure that:
a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b) [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 5, 2017, during the tour of the home, Inspector #672 noted the following:

In the Spa Room, there was an unlabeled green/black hair brush located on top of the shelf, along with an unlabeled small, black comb. Both had hair in them, and appeared to have been used. There were 2 unlabeled curling irons noted on the top of the shelf, 1 Revlon iron, and 1 Sunbeam iron, both appearing to have been used. Further down the shelf, Inspector #672 noted an open jar of VitaRub, approximately 2/3 full, which was unlabeled. On the back of the toilet in the Spa room, there was an unlabeled urine collection "hat".

On June 5, 2017, Inspector #672 interviewed PSW#100, who indicated that although every resident should have their own hairbrush/comb, the hairbrush and comb located in the Spa room are sometimes used, if a PSW forgets to bring the resident's personal items with them to the Spa room, when having their bath/shower. In regards to the curling irons noted on the shelf in the Spa room, PSW#100 indicated that they were not resident specific, and were used on any resident who wished to have their hair curled after their bath/shower. Regarding the unlabeled, open jar of VitaRub, PSW#100 stated that every resident should have their own jar, but that perhaps it had been used if the PSW forgot to bring the resident's personal jar down the the Spa room. Related to the unlabeled urine collection "hat" PSW#100 stated that the urine collection "hat" was not resident specific, and was used for any resident if staff were attempting to collect a urine specimen, or to empty a catheter bag prior to a resident having their bath/shower.

Interview with the Administrator was conducted by Inspector #672, where the Administrator indicated it was the expectation of the home that every resident had their own personal hair brush/comb or curling iron, all personal items should be labeled, and used only for the resident the item belonged to, and that every urine collection "hat" be used to collect one specimen only, and then disposed of.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident did not immediately report the suspicion and the information upon which it was based to the Director.

Related to log #001349-17:

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the MOHLTC on a specified date at a specified hour regarding a physical altercation

between resident #023 and #024 on a specified date at a specified hour.

The CIR indicated that on the specified date at the specified hour, the Administrator was having a conversation with resident #024 near the nurse's station. Resident #023 was walking down the hall towards the Administrator and resident #024. Resident #024 loudly asked the Administrator a negative question regarding resident #023. Resident #023 continued to walk towards the nurse's station. Resident #023 reached around the Administrator and grabbed resident #024's shirt collar while the Administrator was speaking to resident #024 about the comment made towards resident #023. Resident #023 also slapped resident #024 causing an injury. Resident #024 also had an injury. The Administrator and RN #106 immediately intervened to separate the two residents and resident #024 was noted to be weepy following the incident and couldn't understand why resident #023 would strike another resident.

On a specified date at a specified hour, the Administrator contacted the Ministry of Health and Long-Term Care (MOHLTC) action line to report a physical altercation between resident #023 and #024.

Inspector #601 reviewed resident #023 and #024's progress notes for a six month period in 2017. During this period of time, resident #023 and #024 had two other documented physical altercations that resulted in an injury.

On a specified date at a specified hour, RN #121 documented that resident #023 and #024 were yelling loudly in the hallway outside of a resident's room. RN #121 documented that she observed resident #024 trying to free their right hand from resident #023's grab. RN #121 intervened and resident #023 released resident #024's hand when instructed by RN #121. Resident #023 explained to RN #121 that resident #024 had been where they didn't belong and that resident #024 had bitten resident #023. Resident #024 was assessed and no injury was noted following the altercation. RN #121 documented that resident #023 had an injury.

On a specified date at a specified hour, RN #122 documented that resident #024 pushed resident #023, and that resident #023 verbally threatened resident #024. Resident #023's fist got caught up in resident #024's sweater while attempting to hit resident #024. RN #122 documented that staff intervened and resident #024 had no injury and that resident #023's sustained an injury.

During an interview on June 13, 2017at approximately 0930 hour, the Administrator

indicated to Inspector #601 that upon becoming aware of the incidents on the two dates, an immediate internal investigation was completed. The Administrator indicated that following the licensee's investigation it was determined that a CIR was not required. During the same interview, the Administrator indicated that an injury had occurred following both altercations between resident #023 and #024 and the MOHLTC should have been immediately notified. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs which are administered to residents are in accordance with the directions for use as specified by the prescriber.

Review of the licensee's medication incidents which occurred between a three month period in 2017 was conducted by Inspector #672. It was noted that eleven medication incidents occurred during this time period.

Resident #006 had a medication order for a specified date, related to an upcoming medical procedure.

Review of the Prescriber's Fax Order Sheet revealed the medication was not to be ordered any earlier than one week prior to the procedure, as the medication looses potency. The order also revealed that resident #006 was to start using the medication the morning of the procedure, with the first dose administered five to ten minutes prior to the procedure. Following the procedure, the medication was to be used for five days.

Review of resident #006's electronic Medication Administration Record (eMAR) for that time period revealed that on a specified date, the medication order was visible on the eMAR, and the Registered Nursing staff began to administer the medication to resident

#006.

A Medication Incident Report was submitted on a specified date, for the medication error which occurred on that date. Review of the Medication Incident Report revealed that later in the day, during one of the medication administrations, resident #006 questioned the nursing staff as to why the medication was being administered. During that conversation, resident #006 informed RN#106 that the medication wasn't due to be started until the morning of the procedure. RN#106 immediately reviewed the order, put the order on hold in the eMAR system, and informed the pharmacy of the error. The medication was then discontinued on the eMAR system, and restarted as per the original doctor order.

Review of resident #006's specified eMAR revealed that the medication was administered and signed for on a specified date. Inspector #672 interviewed resident #006 on June 13, 2017. Resident #006 verified that the medication had been administered approximately one week prior to the procedure, although the exact date could not be recalled.

Resident #026 became ill on a specified date. Review of resident #026's Digital Prescriber's Orders sheet revealed an order for an antibiotic for seven days.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred over a three day period. On a specified date, RPN#107 noted the medication was still showing on the eMAR system, and continued to be administered to the resident, although the medication was due to have been completed by that date.

Review of resident #026's eMAR revealed that the antibiotic was signed for and administered four times over a two day period. Resident #026 received four extra doses of the antibiotic, with no ill effect noted.

During a specified month in 2017, staff were beginning to notice that resident #026 was having increased pain in the mornings. Review of resident #026's Physician Medication Review revealed an order for an analgesic, to be administered at 0800, 1200, and 1700.

Review of resident #026's 2017 eMAR revealed that on a specified date, staff began administering the 0800 dose of the analgesic at 0600, to assist resident #026's pain during the morning.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred on that date. Review of the Medication Incident Report revealed that during the 1200 medication pass, RPN#107 noted there were multiple routine analgesic orders documented and available in the eMAR system. With the Registered Staff following the eMAR system, and administering the analgesic as displayed by the system, resident #026 was receiving 3000Gm of the medication by 1200 each day. On a specified date, RPN#107 deleted the duplicate order from the eMAR system, to ensure resident #026 only received the medication as ordered.

Resident #012 became ill on a specified date. Review of resident #012's Prescriber's Fax Order sheet revealed an order for an antibiotic for ten days.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred over a two day period. On a specified date, RPN#107 noted the antibiotic was due to have been completed on a specified date, but was still showing on the eMAR system, and continued to be administered to the resident.

Review of resident #012's eMAR revealed that the antibiotic was signed for and administered over two days following the ordered completion date. Resident #012 received three extra doses of the antibiotic, with no ill effect noted.

Review of resident #028's Physician Medication Review dated on a specified date revealed multiple medication orders.

A Medication Incident Report was submitted on a specified date, for a medication incident which occurred on that date. The Medication Incident Report revealed that RPN#107 accidentally administered resident #028's medications to resident #010.

Review of the licensee's Medication Error Summary which occurred between a three month period, revealed that of the eleven medication incidents which occurred during that time period, five were medication incidents where the resident received either the incorrect medication, or the incorrect dose of medication, two were late administration of medications, two were transcription errors, and two were procedural errors. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use, as specified by the prescriber. [s. 131. (2)]

Issued on this 4th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2017_578672_0011
Log No. / Registre no:	009555-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 4, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	MAPLEWOOD 12 MAPLEWOOD AVENUE, BOX 249, BRIGHTON, ON, K0K-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rachel Corkery

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The Licensee is hereby ordered to complete the following:

- An interdisciplinary team shall re-assess all residents who use one or more bed rails, if the resident's bed or health condition has changed and if any part of the bed was modified including the side rails and/or the mattress.

-Steps shall be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment when resident's bed or health condition has changed and/or if any part of the bed modified including the side rails or/and the mattress.

-Develop and implement an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rails use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed, and his or her bed system evaluated in accordance with

evidence based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as 'useful resources' and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings´ (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident's right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Resident #006 was observed by Inspector #672 to have bilateral quarter rails positioned in the middle of the bed, in the engaged position when the resident was in the bed. Clinical health records for resident #006 were reviewed, and identified the resident as being at high risk for falls, and that the bed rails were required and utilized to assist with bed mobility and repositioning. During interview on June 9, 2017, with Inspector #672, resident #006 indicated the bed rails were utilized for bed mobility and repositioning during personal care. During an interview on June 9, 2017, PSW#113 indicated to Inspector #672 that resident #006 does utilize the bed rails during completion of personal care, and to assist with bed mobility and repositioning.

On June 9, 2017, the Administer indicated to Inspector #672 during an interview that the Environmental Service Manager (ESM) and Director of Care (DOC) were working together to complete the Side Rail Use Assessment Form for all of the residents in the home currently utilizing bed rails. A package was provided to Inspector #672, reviewing which residents were outstanding for having the assessment completed. Review of the package provided revealed that eleven of the home's forty-nine residents currently had bed rails on their beds, that have not been assessed for the safe use of the bed rails.

On June 15, 2017, during an interview with Inspector #672, the DOC indicated that where bed rails are being used, the residents have not been assessed, nor has the bed system been evaluated in accordance with evidence based practices.

(672)

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an interview on June 7, 2017 with the Environment Services Manager (ESM), Inspector #672 was informed that a bed entrapment audit had been completed in the home in July 2016, and there were several resident beds in use, with failed entrapment zones.

Review of the licensee's current bed system evaluation was conducted by Inspector #672. The bed entrapment audit indicated that eleven out of the forty-nine beds in the home failed one or more entrapment zones. During an

interview on June 8, 2017, the Administrator indicated to Inspector #672 that the home purchased new equipment last year, including beds, and there was a goal to purchase more, on an ongoing annual basis, as the budget allowed, to replace the systems which have failed. The Administrator also informed Inspector #672 that the ESM and Director of Care (DOC) were working together to assess all residents for entrapment risks, with interventions to be put in place to ensure their safety, should they currently be in a bed with one or more failed zones.

During an interview on June 15, 2017 with Inspector #672, the DOC indicated that no interventions or accessories have been implemented to reduce the risk of entrapment for the eleven residents currently in bed systems with one or more failed zone. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A compliance order is being issued related to the severity and scope of the evidence. Bed system evaluation completed in the home during July 2016 identified 11 of the 49 beds failed one or more entrapment zones, with minimal measures being implemented to eliminate the risk to residents.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 4th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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