Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2016	2016_395613_0001	034909-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

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

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

LISA MOORE (613), CHAD CAMPS (609), JENNIFER LAURICELLA (542)

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): January 4 - 8 and 11 - 15, 2016

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Executive Director of Care (EDOC), Manager of Environment & Property, RAI Coordinator, Payroll Administrator, Registered Nursing staff (RN Supervisors/RPNs), Personal Support Workers (PSW), Equipment Distributor and Housekeeping staff.

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the residents home area and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing
Training and Orientation

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

16 WN(s)
11 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A review of 12 resident beds was completed on January 14, 2016 by Inspector #609, and they found that six of the beds or 50 per cent had mattresses not secured to the bed frame and were easily moved by the Inspector.

During an interview with the bed safety lead RN Supervisor #119, they confirmed that beds without secured mattresses were unable to be properly assessed for safety and entrapment.

During an interview with the Executive Director of Care (EDOC), they confirmed that it was the expectation of the home that where bed rails were used other safety issues related to the use of bed rails was to be addressed, that in the case of the six insecure mattresses on resident beds, this did not occur and should have.

During an interview with the home's Equipment Distributor #118, they confirmed that any testing of the bed including entrapment risk assessments were not valid when the mattresses moved significantly on the frame. The Equipment Distributor #118 revealed an audit of all beds in the home was completed on January 14, 2016, revealing 41 beds in the home did not have secure mattresses to the bed frames, that corner keepers to secure the beds were ordered January 14, 2016, and velcro would be applied to the mattresses until the corner keepers were attached to the beds. [s. 5.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #012's right to participate in decision-making was fully respected and promoted.

During an interview with resident #012, they stated that in January 2016, despite continually refusing to get out of bed as they felt unwell, RPN #109 and PSW #110 transferred them to their wheelchair and attempted to take them out of their room. Resident #012 became very upset and staff eventually left them alone.

During an interview with RPN #109, they confirmed the account of the events that

transpired in January 2016, by resident #012. RPN #109 indicated that care was provided to resident #012 despite their objections because the plan of care specified that resident #012 was to be up at that time.

During an interview with RPN #109, they further confirmed that the plan of care was agreed to by the resident's Power of Attorney (POA) and acknowledged that there was no process to ascertain whether a POA was enacted or not and that in the case of resident #012 had assumed that the resident was incapable of making their own decisions.

During an interview with RN Supervisor #104, they confirmed that the home needed to develop additional training and processes to assist staff in determining which residents have enacted POA's and which do not in order to care plan accordingly.

During an interview with the Executive Director Of Care (EDOC), they confirmed that it was the expectation of the home that resident's participation in decision-making was fully respected and promoted, that in the case of resident #012 being transferred out of bed without their consent in January 2016, and the changes to their care plan done with the resident's POA this did not occur and should have. [s. 3. (1) 9.]

2. The licensee failed to ensure that every resident had the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On January 11, 2016, Inspector #613 observed RPN #111 administer medications to resident #013 and disposed the emptied labelled medication packages into an open garbage receptable located on the right hand side of the medication cart. The emptied labelled medication packages were easily seen by other residents, staff or visitors that walked by the medication cart. A short time later, the Inspector walked by another medication cart on another unit and observed an emptied labelled medication package in the opened garbage receptable attached on the right hand side of the medication cart. The emptied labelled medication package clearly identified resident #014's name, medication and date to be administered. Resident's #013 and #014's confidentiality was not maintained.

On January 13, 2016, Inspector observed RPN #107 administering medications to

residents in a common area. RPN #107 was observed opening medication packages to administer medications then after administering medications, dispose of labelled medication package into the open garbage receptable attached at the side of the medication cart. Inspector walked by the medication cart and could visibly observe the name of resident and their medication on the labelled package located in the open garbage receptable. Resident #011's confidentiality was not maintained.

The Inspector interviewed RPN #107, RPN #114 and RN Supervisor #100 who all confirmed that it was registered staff's practice to dispose of resident's labelled medication packaging in the garbage receptable on the medication cart, then that garbage bag is placed into a larger garbage bag in the medication room by the registered staff and then housekeeping staff provide regular disposal which is not for confidential waste.

On January 13, 2016, at 1150 hours, Inspector #609 provided Inspector #613 a labelled medication package that was located on the ground outside in front of the basement entrance/exit door of the Long Term Care home. The labelled medication package did not contain medications and was opened on the left lower corner. The labelled medication package identified resident #015's name, medication dosage and date to be administered. This labelled medication package was located in an area that many staff enter/exit to get to the staff parking lot. Resident #015's confidentiality was not maintained.

On January 13, 2016, at 1330 hours, Inspector #613 observed a labelled medication package that was located on the ground outside in front of the basement entrance/exit door of the LTC home. The labelled medication package did not contain medications and was opened on the right upper corner. The labelled medication package identified resident #016's name and medication dosage . The date was torn off the package. Resident #016's confidentiality was not maintained.

The Inspector reviewed the home's policy titled, 'Medication, Drug Destruction & Disposal', revised July 2015. The policy did not identify the procedure for medication package disposal nor did it identify maintaining and respecting all resident's confidentiality during medication administration. RN Supervisor #104 confirmed the home did not have policy.

During an interview on January 14, 2016, the Executive Director of Care (EDOC) confirmed that the registered staff's practice for disposal of resident's labelled medication

packaging was as RPN #107, RPN #114 and RN Supervisor #100 had reported to the Inspector. The EDOC confirmed that this practice did not maintain residents' confidentiality. [s. 3. (1) 11. iv.]

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 resident #012's right to participate in decision making is fully respected and promoted and that every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 licensee failed to ensure that the plan of care sets out clear direction to staff and

others who provide direct care to resident #009.

A health care record review was completed for resident #009. The most current Resident-Assessment Instrument-Minimum Data Set (RAI- MDS) assessment indicated that resident #009 displayed responsive behaviours.

The most current care plan that was accessible to staff did not include these behaviours or interventions to manage them. The care plan for resident #009 indicated that interventions to manage the resident's responsive behaviours would be found in a specific section of the care plan. The Inspector was unable to locate that specific section and interventions on the care plan.

On January 12, 2016, Inspector #613 met with PSW #113 and RPN #107, who both confirmed that the resident does display behaviours. RPN #107 reviewed the care plan and confirmed the section noted above, was not on the care plan that was accessible to all staff and that the information should have been on the care plan. RPN #107 confirmed that the care plan was unclear and did not provide interventions to direct care staff for resident #009's responsive behaviours.

During an interview on January 12, 2016, RN Supervisor #100, they reported to the Inspector that all information with regards to resident #009's care interventions would be located on the care plan.

During an interview on January 14, 2016, the Executive Director of Care, they confirmed that all information to care for resident #009 was to be in the resident's care plan and that it was the home's expectation that all resident's care plans provided clear direction to staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #010 was reassessed and the plan of care was 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 was no longer necessary.

A health care record review was completed for resident #010. The most current care plan available to the direct care team indicated that the resident displayed responsive behaviours.

Inspector #542 reviewed the November and December 2015, Point of Care charting that was completed by the Personal Support Workers. There was no documentation to

support that resident #010 exhibited responsive behaviours.

During an interview with PSW #108, they indicated that they had not witnessed any responsive behaviours from resident #010.

During an interview with PSW #113, they confirmed that resident #010 did not have responsive behaviours.

During an interview with the Back Up RAI-Coordinator #111, they confirmed that the care plans that were accessible to the direct care team were to be reviewed and revised by the staff working on the units and the RAI department updates the care plans quarterly. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear direction to staff and others who provide direct care to resident #009 and that resident #010 are reassessed and the plan of care is 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy instituted or otherwise put in place was complied with.

On January 11, 2016, Inspector #613 completed a review of the narcotics and controlled substances for one unit. The Inspector reviewed the narcotic control count sheets and observed discrepancies for resident's #017 and #018. The scheduled controlled substances medications were not signed as being administered at the scheduled times and the count was off as follows;

For resident #017, the narcotic control count sheet identified a controlled substance that was administered each day. The count should have been six and a half tablets remaining but there were seven tablets remaining. The medication blister pack had six and a half tablets remaining; however, the narcotic control count sheet identified that there were seven tablets in the medication blister package. The form identified that one half tablet was not accounted for by the registered staff.

For resident #018, the narcotic control count sheet identified a controlled substance that was administered each day. The count should have been 11 tablets remaining but there were 12 tablets remaining. The medication blister pack had 11 tablets remaining; however, the narcotic control count sheet identified that there were 12 tablets in the medication blister package. The form identified that one tablet was not accounted for by the registered staff.

RN Supervisor #104 confirmed the narcotic count discrepancy and confirmed that both medications should have been signed for by RPN #109 when the controlled substances were administered.

The Inspector spoke with the registered staff assigned to this unit, RPN #109 who confirmed they had administered the medications to both residents as ordered and they were aware that they did not sign for the medication on the narcotic control count sheets. RPN #109 reported to the Inspector that it was the home's expectation to sign for the medications on the narcotic control count sheets right after it was administered to the resident.

The Inspector reviewed the home's policy titled, 'Medication Administration,' last revised October 2015 that identified for every medication administered, there shall be a record

that includes date, time, dose and route where applicable, signed by the person who gave the medication.

During an interview on January 14, 2016, the Executive Director Of Care (EDOC) confirmed that registered staff were to sign in the Mede-care emars and the narcotic control count sheets immediately following administration of narcotics and controlled substances. The EDOC confirmed RPN #109 did not follow the home's policy. [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 the home's Medication Administration policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During the initial tour of the home, Inspector #542 observed that under several hand sanitizer units on the walls were marked with a dried substance all down the walls from the hand sanitizer liquid. As well, the hand rails in each home area contained

soiled/stained sections. On the wall directly under the hand rails in the hallways, the fabric on the wall was stained/soiled in many areas.

It was also observed on one of the units that there was a large amount of debris accumulated beside the trim on the floor. A lounge area contained a soiled/stained recliner chair that residents were often occupying. Also, at the end of a hallway, a sofa was noted to be stained/soiled.

During an interview with housekeeping staff #123, they confirmed that this unit had not had any deep cleaning completed during 2014 and 2015.

During an interview with Manager #122, they confirmed that this specific unit had not been deep cleaned for two years. They also indicated that it would be completed by April 2016. The Manager also agreed that the home required some repair, specifically the walls, furnishings and the deep cleaning. [s. 15. (2) (a)]

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

During the initial tour of the home, Inspector #542 observed that numerous resident home areas had chipped paint and scuff marks on the walls. The shower room doors in both home areas were painted; however, the paint was scratched off in numerous places.

The dining room located on a unit had a portion of the dry wall exposed under the hand sanitizer unit and the counter top was in very poor condition.

On the wall directly under the hand rails in the hallways, the fabric on the wall was coming off of the wall in some areas.

An interview with Manager #122 confirmed that the home required some repair, specifically the walls, furnishings and the deep cleaning. [s. 15. (2) (c)]

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 home, furnishings and equipment are kept clean and sanitary as well as maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication response system for residents #003, #005 and #009 could be easily seen, accessed, and used by residents, staff and visitors at all times.

On January 4, 2016, the Inspector observed the call bell for resident #003 on the floor beside the resident's bed where it was not easily seen or accessible to the resident.

On January 16, 2016, Inspector #609 observed resident #003 in their wheel chair with no call bell within reach of the resident.

Inspector #613 observed resident #005 on various days and times and their call bell was wrapped around the left bed rail and dangling towards the ground. The Inspector had difficulty getting the call bell out from between the wall and bed rail for the resident to use. Resident #005's call bell was not easily seen or accessible.

The Inspector completed a health care record review for resident #005. The most current care plan that was accessible to staff identified to ensure resident had their call bell.

The Inspector observed resident #009 on various days and times and their call bell was lying wrapped around its cord on resident's night table, the call bell was situated on the far left corner of the night table, positioned towards their room mate's bed or the call bell was on the floor. Resident #009's call bell could be seen but was not in reach of resident when they were lying on their bed.

The Inspector completed a health care record review for resident #009. The most current care plan accessible to staff did not have any documentation for staff regarding call bell placement for resident #009.

During an interview with RN Supervisor #100, PSW #106, PSW #113 and RPN #114, they confirmed that it was the expectation of the home that the call bells could be easily seen, accessed, and used by residents at all times. They also confirmed that in the cases of no call bell within reach for residents #003, #005 and #009 on several separate days this did not occur and should have.

During an interview on January 14, 2016, with the Executive Director of Care (EDOC), they confirmed that the call bell was to be within reach for all residents. [s. 17. (1) (a)]

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 resident-staff communication response system for residents #003, #005 and #009 can be easily seen, accessed and used by the residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: 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 failed to ensure that the 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 immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CI) was submitted to the Director in June 2015 which outlined staff to resident abuse allegations by another staff member related to events that occurred earlier in June 2015.

A review of the home's policy titled, 'Abuse of Residents, Preventing, Reporting, and Eliminating,' last revised May 2015 revealed all employees and volunteers at the home who witnessed or suspected the abuse of a resident were to report the matter immediately to their direct supervisor who, in turn, reports the same to the EDOC.

A review of the home's internal investigation of the abuse allegations revealed the staff member who suspected abuse did not report it immediately to their supervisor which resulted in a 21 hour gap in reporting to the Director.

During an interview with the EDOC, they confirmed that it was the expectation of the home that any 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 was to report it immediately to their supervisor, that in the case of the cited staff member who did not immediately report their suspicions of abuse and the resulting delay in reporting to the Director, this did not occur and should have. [s. 24. (1)]

2. A Critical Incident Report (CI) was submitted to the Director in January 2016, which outlined allegations of staff emotional abuse toward resident #012 that was reported to the home earlier in January 2016.

During an interview with the EDOC, they stated that the home did not define the allegations made by resident #012 as abuse and as a result did not report the information to the Director for over 24 hours.

A review of the abuse decision tree for reporting to the Director as well as the LTCHA and Regulations was conducted with the EDOC. The EDOC confirmed that it was the expectation of the home that the 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 would immediately report the suspicion and the information upon which it was based to the Director. In the case of the cited allegations of abuse made to the home in January 2016, by resident #012 this did not occur and should have. [s. 24. (1)]

3. The licensee failed to ensure that the alleged verbal abuse of resident #011 was immediately reported to the Director.

A Critical Incident (CI) was submitted to the Ministry in November 2015, which indicated that a staff member was alleged to have been abusive towards residents #002 and #011

on two separate dates.

Inspector #542 received the home's investigation file from the EDOC. A review of the file revealed that the staff member was witnessed being verbally abusive towards two residents on two separate dates. The witnesses reported the verbal abuse to the home in November 2015 however the first occurrence of verbal abuse had occurred seven days prior in November 2015.

An interview with the EDOC confirmed that the witnesses did not report the abuse immediately. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has 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 immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of resident #002 that included any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

The most recent care plan available to the direct care staff identified that resident #002 exhibited responsive behaviours. The Point of Care (POC) charting that was completed by the Personal Support Workers (PSWs) during the month of November and December 2015 identified that the resident exhibited specific responsive behaviours.

Over the course of the inspection, Inspector #542 observed resident #002 displaying a specific responsive behaviour.

During an interview with RPN #121, RPN #111, PSW #113, and PSW #108, they confirmed that resident #002 has specific responsive behaviours. RN Supervisor #119 indicated that resident #002 also exhibited other responsive behaviours.

During an interview with RN Supervisor #104, RN Supervisor #119 and RPN #111, they

confirmed that resident #002's has specific responsive behaviours. RN Supervisor #119 also confirmed that the most current care plan should have included all responsive behaviour exhibited by the resident. [s. 26. (3) 5.]

2. The licensee failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.

In the morning, on January 12, 2016, Inspector #609 observed that resident #001 was not properly groomed.

A review of the plan of care for resident #001 revealed no mention of specific grooming tasks.

A review of the clinical record for resident #001 between December 2015, and January 2016, revealed a specific grooming task was done by staff four times and it was last completed by staff 19 days ago.

During an interview with RN Supervisor #100, they confirmed that it was the home's expectation that the type, level of assistance and frequency that the resident required for grooming should have been in the plan of care and that in the case of the grooming needs of resident #001 this did not occur and should have. [s. 26. (3) 7.]

3. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A review of the plans of care for resident #002, #010 and #008 was conducted on January 14, 2016, which revealed that one of three or 33 per cent of the plans of care reviewed did not have sleep patterns and preferences identified.

During an interview with RN Supervisor #120, they confirmed that it was the expectation of the home to be in compliance with the Regulation, that in the case of the cited care plan for resident #002 without sleep patterns and preferences identified the home was not in compliance with the LTCHA and Regulations and should be. [s. 26. (3) 21.]

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 plan of care is based on at a minimum, interdisciplinary assessment of mood and behaviour patterns, including wandering, and any potential behavioural triggers and variations in the resident's functioning at different times of the day, specific to resident #002; the physical functioning and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming, specifically in regards to resident #001; and sleep patterns and preferences for residents #002, #010 and #008, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident #001 was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment was required.

During stage one of this inspection, the Inspector observed that resident had oral care concerns.

During an interview with the POA for resident #001, they stated that they were not offered an annual dental assessment by the home.

During an interview with RN Supervisor #100, they stated that on admission, the home would offer the resident and family the services of a dental hygienist. RN Supervisor #100 confirmed that the home did not annually offer a dental assessment to residents other than on admission.

An interview was conducted with RN Supervisor #100 who confirmed that it was the expectation of the home to be in compliance with the LTCHA and Regulations, that in the case of no offering of an annual dental assessment to residents, the home was not in compliance and should be. [s. 34. (1) (c)]

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 resident #001 is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents had their personal items labelled with in 48 hours of admission and in the case of new items, of acquiring.

Observations during stage one of the inspection revealed:

- three pairs of eye glasses were not labelled in three different resident's rooms.
- one blue electric razor was not labelled in a resident's room.
- an unlabelled pink/white toothbrush on the shelf in the resident's shared bathroom (a shared bathroom for four residents).
- two blue denture cups were not labelled on the shelf in two different resident's shared bathrooms (a shared bathroom for four residents) - there were no dentures in either of the unlabelled denture cups.

Inspector met with RN Supervisor #100 who reported that the home's expectation was for staff to label resident care personal items on admission or when a resident receives new personal care items.

During an interview on January 14, 2015, the Executive Director of Care (EDOC) confirmed that the home's expectation is that residents' personal care items were to be labelled immediately on admission or at other times as new items arrive. [s. 37. (1) (a)]

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 residents had their personal items labelled with in 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the behavioural triggers have been identified for resident #002 demonstrating responsive behaviours.

During an interview with PSW #108, PSW #113, RPN #121, RN Supervisor #104, and RN Supervisor #119, they identified that a potential trigger for resident #002's responsive behaviours were certain staff members or other residents. The PSW staff indicated that sometimes certain staff members could cause resident #002 to display responsive behaviours.

A review of the health care record for resident #002 revealed several responsive behaviours included on the most recent care plan. The most current care plan did not identify this specific responsive behaviour trigger. [s. 53. (4) (a)]

2. The licensee failed to ensure that the actions taken to meet the needs of resident #002 with responsive behaviours included assessments, reassessments, interventions and the resident's responses to interventions documented.

A review of resident #002's health care record was completed. The most recent care plan identified that they exhibited responsive behaviours.

The most recent RAI-MDS assessment from November 22, 2015 identified that resident #002 demonstrated responsive behaviours.

Over the course of this inspection, the Inspector observed that resident #002 exhibited a specific responsive behaviour.

A review of the Point of Care (POC)charting over a two month period revealed that the resident exhibited specific responsive behaviours.

During an interview with RAI Coordinator #100, they confirmed that the RAI department updates the care plans on the computer quarterly and that it was the responsibility of the nurses on the units to ensure the paper copy of the care plans were updated when there was a change in the resident's status.

Interviews were conducted with numerous direct care staff and it was noted by Inspector #542 that the staff did not have consistent answers of what the resident's responsive behaviours were. Furthermore the RAI-MDS assessment and the most current care plan did not contain the same responsive behaviours.

During an interview with RN #119 and RN #104, they confirmed that the home did not complete a reassessment of the resident's responsive behaviours, nor was the care plan up to date to reflect resident #002's current responsive behaviours. [s. 53. (4) (c)]

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 behavioural triggers have been identified for resident #002 demonstrating responsive behaivours and to ensure that actions taken to meet the needs of resident #002 includes assessments, reassessments, interventions and their response to interventions are documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff had received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

A Critical Incident Report (CI) was submitted to the Director in June 2015, which alleged PSW #103 was verbally abusive to a resident.

A review of the home's 2015 annual retraining of staff on abuse awareness and prevention revealed that 24 staff members or 16 per cent of the home's total staffing complement had not completed the required annual retraining on zero tolerance of abuse and neglect of residents.

A further review of the 2015 annual retraining of staff revealed that PSW #103 who was implicated in allegations of abuse had not completed the 2015 retraining.

During an interview with the EDOC, they confirmed that it was the expectation of the home that all staff were to complete the annual retraining on zero tolerance of abuse and neglect of residents that in the case of the 16 per cent of staff who had not completed the required retraining and they should have. [s. 76. (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 all staff receive retraining annually to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written record of each annual evaluation of the restorative care program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During an interview with RN Supervisor #100, they stated that they were the lead for the restorative care program. RN Supervisor #100 confirmed that an evaluation of the restorative care program occurs bi-monthly to quarterly which addresses specific resident needs.

RN Supervisor #100 also confirmed that there was no written annual evaluation of the restorative care program.

An interview was conducted with RN Supervisor #100, they stated that it was the expectation of the home to be in compliance with the LTCHA and Regulations, and that in the case of no written annual evaluation of the restorative care program, the home was not in compliance and should be. [s. 30. (1) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #002 and #011 and their substitute decision makers were notified of the results of the alleged abuse investigation immediately upon the completion.

A Critical Incident (CI) was submitted to the Ministry in November 2015, which indicated that a staff member was alleged to be abusive towards residents #002 and #011.

A review of the home's investigation file revealed that the investigation was completed later in November 2015 resulting in termination of the employee.

As per the home's investigation notes, it revealed that in December 2015 a family member for resident #002 approached a registered staff and asked for the results of the home's investigation. A letter was sent to the family of resident #002, 13 days after the investigation was completed.

The investigation file did not indicate that resident #011 or their family were notified of the results of the investigation.

An interview with the Executive Director of Care (EDOC) was conducted. The EDOC indicated that resident #011 and their family member did not wish to be notified of the results.

During an interview with resident #011's family member, they confirmed that the home did not inform them of the results of the investigation and that they had not told the home that they did not wish to be notified of the results of the investigation. [s. 97. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to resident #009 that resulted in a significant change in the resident's health condition and for which the resident was taken a hospital.

Inspector #613 completed a health care record review for resident #009. The Mede-care notes identified that resident had a fall in October 2015 that resulted with transfer to hospital due to an injury. Resident #009 returned to the home on the same date with no acute findings.

The Mede-care notes identified that one day after the fall occured in October 2015, resident #009 was transferred again to the hospital and was diagnosed with an injury. Resident returned to the home on this date.

The Inspector reviewed the RAI – MDS assessments, RAPS and Mede-care notes, which all identified the resident's status as a significant change and noted decline in their overall functioning.

During an interview on January 8, 2016, with RN Supervisor #100, they reported to the Inspector that resident #009 was independent with ambulation and Activities of Daily Living (ADL's) before their fall in October 2015. RN Supervisor #100 reported that after the fall, resident #009 required an assistive device, regular analgesics and assistance from staff to meet their daily care needs (ADL's).

On January 14, 2016, the Inspector met with the Executive Director of Care who confirmed that a Critical Incident had not been submitted to the Director and that the documentation in the Mede-care notes identified resident #009's injury and status as a significant change. The EDOC stated that a Critical Incident was not submitted to the Director due to their consultation with the home's RAI team who deemed resident not to be significant change; however, they did code resident #009 as such in the home's documentation. The EDOC confirmed that a Critical Incident should have been submitted to the Director due to the significant change in resident #009's status. [s. 107. (3) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the results of the annual evaluation of the medication management system and any changes that were implemented.

Inspector #613 reviewed the Interdisciplinary Care Advisory Committee minutes for 2015 (April, September and December) that identified that there was no written annual evaluation of the home's medication management system.

During an interview on January 14, 2016, with RN Supervisor #104, they reported to the Inspector that they did not have a written record of the results of the annual evaluation of the medication management system. RN Supervisor #104 confirmed that the interdisciplinary team did not review the quarterly evaluations of the previous year, did not use an assessment instrument and did not identify changes that were implemented.

During an interview on January 14, 2016, the EDOC was unable to provide a written annual evaluation of the medication management system and they confirmed it had not been completed. [s. 116. (5)]

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), CHAD CAMPS (609), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2016_395613_0001
Log No. / Registre no:	034909-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2016
Licensee / Titulaire de permis :	THE ONTARIO-FINNISH RESTHOME ASSOCIATION 725 North Street, Sault Ste Marie, ON, P6B-5Z3
LTC Home / Foyer de SLD :	MAUNO KAIHLA KOTI 723 North Street, Sault Ste Marie, ON, P6B-6G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Belair

To THE ONTARIO-FINNISH RESTHOME ASSOCIATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall:

a) Ensure all the mattresses in the home are secured to the bed frames as per the manufacturer's recommendations.

b) Complete on-going audits to ensure that all mattresses are secured to the bed frames, and records are maintained of the audits and any interventions required to correct.

c) Ensure that where bed rails are used, the residents are assessed and steps are taken to prevent entrapment, taking into consideration all potential zones of entrapment.

d) Ensure all bed systems are evaluated in accordance with evidence-based practices to ensure resident safety and mattresses fit securely to the bed frames.

e) Ensure training and retraining of staff includes education of the home's policies and procedures related to bed entrapment zones, safety of securing mattresses to the bed frames and the home's responsibility for maintaining a safe and secure environment for the residents.

Grounds / Motifs :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A review of 12 resident beds was completed on January 14, 2016 by Inspector #609, and they found that six of the beds or 50 per cent had mattresses not secured to the bed frame and were easily moved by the Inspector.

During an interview with the bed safety lead RN Supervisor #119, they confirmed that beds without secured mattresses were unable to be properly assessed for safety and entrapment.

During an interview with the Executive Director of Care (EDOC), they confirmed that it was the expectation of the home that where bed rails were used other safety issues related to the use of bed rails was to be addressed, that in the case of the six insecure mattresses on resident beds, this did not occur and should have.

During an interview with the home's Equipment Distributor #118, they confirmed that any testing of the bed including entrapment risk assessments were not valid when the mattresses moved significantly on the frame. The Equipment Distributor #118 revealed an audit of all beds in the home was completed on January 14, 2016, revealing 41 beds in the home did not have secure mattresses to the bed frames, that corner keepers to secure the beds were ordered January 14, 2016, and velcro would be applied to the mattresses until the corner keepers were attached to the beds.

The scope of this issue was a pattern of unsafe and insecure mattresses in the home. Although, there was no previous non compliance related to this, the severity was determined to be a potential harm to the health, safety and security of the residents of the home. (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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