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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2015	2015_235507_0013	T-2399-15/T-2400-15	Follow up

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET NORTH YORK ON M2K 1E1

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

SENIORS' HEALTH CENTRE
2 BUCHAN COURT NORTH YORK ON M2J 5A3

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 8, 9, 10, 15, 16, 17, 18, 19, 22 and 23, 2015.

Inspector Susan Squires (109) was part of the inspection team. Findings identified for non-compliances for Resident #006 related to LTCHA s.6(1)c, s.6.7 and s. 6.9 were collected by Inspector #109.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOCs), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Food Service Supervisor (FSS), Environmental Services Supervisor (ESS), Maintenance Workers (MWs), Scheduler, Vice President, Clinical Support, Integration and Strategy of North York General Hospital, Director of Planning of Facilities of North York General Hospital, Representatives from ProResp and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2015_205129_0001	507

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

As required under section 90(h) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Review of the home's policy titled, "Water Temperature Monitoring" (policy #: VII-H-10.26, revised September 2007) indicated the temperature of the hot water serving all bathtubs, showers and sinks used by residents must maintain at a temperature between 40 and 49 degrees Celsius, and will be monitored daily once per shift in random locations where residents have access to hot water. The policy further stated the procedure as followed:
i) Registered nursing staff must monitor hot water temperatures in random resident home areas (resident bathrooms, tub rooms, and public bathrooms) on each shift by running the hot water tap for five minutes, inserting the water temperature thermometer into the stream of water for 15 seconds then reading the temperature on the dial/ panel.
ii) Registered nursing staff must report all water temperatures above 49 degrees to maintenance personnel for adjustment and appropriate intervention and document all reports and follow up in the "Comments" column of the monitoring form.

iii) Personal Support Workers (PSWs) must immediately report all water temperature over 49 degrees Celsius to the registered nursing staff.

Review of the "Resident Care Area Water Temperatures" records for three identified floors for a period of 11 weeks revealed that the water temperature in one or more resident rooms exceeding 49 degrees Celsius occurred almost daily. A total of 234 times of water temperature exceeding 49 degrees Celsius was recorded in 70 resident rooms in the above mentioned period. Among them, 25 records indicated the water temperature in random resident rooms exceeded 52 degrees Celsius, and the highest was 54.2 degrees Celsius recorded on an identified date in an identified resident room.

Interview with staff #116 revealed that his/her practice was to call the maintenance department to report any water temperature exceeding 49 degrees Celsius. Interview with staff #115 revealed that any maintenance request should be documented on the maintenance request logbook, including water temperatures exceeding 49 degree Celsius.

Review of the maintenance log books on the three identified floors failed to reveal that the maintenance staff were notified of hot water temperatures exceeding 49 degrees Celsius by the nursing staff as indicated in the home's "Water Temperature Monitoring" policy during the above mentioned period. An interview with staff #112 and #131 confirmed that maintenance department did not receive any report from the nursing staff, verbally or written, related to water temperatures exceeding 49 degree Celsius in the above mentioned 11 weeks' period. Since the maintenance department did not receive a report of water temperature exceeding 49 degrees Celsius, no immediate actions were taken to reduce the water temperature on those occasions. On an identified date, the concern related to no immediate action taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius was brought to the attention of staff #108 and the MWs, and staff #108 confirmed that no immediate actions were taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius in the above mentioned period as required under the Regulation. [s. 90. (2) (h)]

2. The licensee failed to ensure that the water temperature is monitored once per shift in random locations where residents have access to hot water.

As required under section 90(k) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations

where residents have access to hot water.

Review of the home's policy titled, "Water Temperature Monitoring" (policy #: VII-H-10.26, revised September 2007) indicated that the temperature of the hot water serving all bathtubs, showers and sinks used by residents are to be monitored daily once per shift in random locations where residents have access to hot water.

Review of the "Resident Care Area Water Temperatures" records for three identified floors for a period of 11 weeks revealed the hot water temperature was not monitored in any resident care areas of the home in 31 shifts.

Interview with staff #105 confirmed that the home was not using a computerized system to monitor the water temperature. Interview with staff #115 revealed that he/she was not aware of the hot water temperature monitoring required every shift, indicating that only the night shift was required to monitor the water temperature. Interview with staff #108 confirmed that the hot water temperature was not monitored once per shift in random locations where residents have access to hot water as required under the Regulation.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
The nursing staff did not notify the maintenance personnel when the water temperature exceeded 49 degrees Celsius, and preventing immediate action being implemented to respond to the elevated water temperature in the 11 weeks period. It was noted that on 234 occasions the water temperature exceeded 49 degrees Celsius in 70 resident rooms during the above mentioned period.

The scope of the non-compliance is a pattern. The frequency of water temperatures exceeding 49 degrees Celsius were noted to occur on three (3) resident home areas in the 11 weeks period. [s. 90. (2) (k)]

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. 87. Emergency plans

Specifically failed to comply with the following:

s. 87. (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations. 2007, c. 8, s. 87. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there are emergency plans in place for the home that comply with the regulations, including measures for dealing with emergencies.

The licensee failed to comply with order CO#001, issued March 13, 2015, during the Critical Incident System Inspection #2015_205129_0001, with an order compliance date of June 1, 2015. The order directed the home to ensure all emergency plans are developed, updated, reviewed and tested
a) Annually: in addition to loss of one or more essential services and fire, situations involving a missing resident, medical emergencies and violent outbursts.
b) Once every three years: community disasters, bomb threat and chemical spills.

The order was issued with the following grounds:
1. There are no emergency plans in place that are home specific and available to staff at the time of inspection.
2. Interviews with the Administrator and Environmental Supervisor and record review confirmed that the home has not evaluated or updated the emergency plans in the home to be home specific since the change in management from speciality Care to Leisureworld.
3. Interviews with the Administrator, director of care, Environmental Supervisor, the home's educator, and reception revealed that staff have not conducted tests in emergency plans annually or at least once every three years for identified emergencies as outlined in the Regulation.

In relation to emergency plans:
1. Under section 230(2) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that all emergency plans are in writing.
2. Under section 230(5)4 of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that the emergency plans address specific staff roles and responsibilities.

a) On an identified date, inspectors (#109 and #507) initiated the follow up inspection of the above Compliance Order. Review of the home`s emergency plans revealed the home's policy titled "Code Orange – Electrical Power Failure" (policy #: XVIII-H-10.40, revised June 2012) has not been updated since the order was issued on March 13, 2015. The written emergency plans concerning the loss of power during a power outage, related to power outages, specifically in relation to the roles and responsibilities of the staff working on two identified floors, were not updated.

Two days later, staff #106 provided the inspectors (#109 and #507) a copy of the home's policy titled "Code Orange – Electrical Power Failure" (policy #: XVIII-H-10.40, revised June 2012), with the following added to the policy in hand writing:
i) the current date was added to the current revision,
ii) once power is restored, staff shall immediately recheck and reconnect all electrical medical devices to the regular power sources, and
iii) a note "Levels I and II require hook up to generator electrical outlets located in hallways, identified by Red Dots when regular power outage occurs" was added to the policy.

The above mentioned revised (draft) policy failed to reveal the specific staff roles and responsibilities in connecting the electric medical devices to the emergency electrical outlets in maintaining functionality during power outage as required under section 230(5)4 of the Regulation 79/10 under the LTCHA.

b) Review of email communications between the home and Toronto Hydro-Electric System Limited and interview with staff #105 confirmed the home experienced three power outages in a period of five weeks and the duration of each occurrence was between five minutes and almost two hours.

Observations and interviews with staff #103, #116, #118, #121, #123, #119, #120, #104 and #115, revealed the following roles and responsibilities in relation to electric medical devices when power outage occurs:
i) Staff on first and second floors must use the extension cord connecting the electric medical devices to the emergency electrical outlet identified with a "red dot" located in the hallway, and
ii) staff on third and fourth floors must use the extension cord connecting the electric medical devices to the emergency electrical outlet identified with a "red dot" located in resident rooms.

c) Interviews with staff #106 and #109 confirmed that when power outage occurs, actions taken in connecting the electric medical devices to the emergency electrical outlets on first and second floors are different from actions taken on third and fourth floors due to the structure of the building. Staff #106 further confirmed there are no emergency electrical outlets in resident rooms on first and second floors; the emergency electrical outlet is located in the hallway.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
The home's emergency plan policy did not include the roles and responsibilities for staff who were working on the first and second floors when the power outage occurs, which was different from staff who were working on the third and fourth floors due to the building structure.

The scope of the non-compliance is wide-spread related to the emergency plan.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.87(2):
A Compliance Order (CO) was previously issued for s.87(2) during a Critical Incident Inspection on January 6, 2015, under inspection #2015_205129_0001. [s. 87. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

a) Review of the physician's order for resident #006 revealed the doctor's order stated to provide specified therapeutic treatment continuously. The medication administration records (MAR) for a period of five weeks did not have directions for the specified therapeutic treatment that was to be provided on a continuous basis in terms of the

rational and the type of equipment and times that each of the specific equipment was used. The resident was using two different types of equipment at different times throughout the day.

Review of physician's order revealed that resident #006 required constant specified therapeutic treatment throughout the day and equipment to be applied during the night. Review of the MAR revealed there were no directions for the application of the specified therapeutic treatment and the equipment that was applied to the resident at night.

The written plan of care for resident #006 stated to maintain the specified therapeutic treatment as ordered by the physician and did not provide any directions for the type of equipment, the rationale and the level of the specified therapeutic treatment.

Interviews with staff #109 and #111 confirmed there were no clear directions to the staff and others who provide care to resident #006 as to the application of the specified therapeutic treatment and related equipment.

b) Review of resident #005's health records revealed that the resident was prescribed an analgesic two tablets by mouth as needed for pain with a specified start date.

Review of the MAR and progress notes revealed the resident requested and was given eight doses of the analgesic in the following 10 days for pain. Review of the progress notes and the physician's order revealed that the resident requested a stronger analgesic for pain control on the eighth day after the analgesic was prescribed, and was prescribed one or two tablets of the same analgesic by mouth every four hours as needed 11 days after the analgesic was initiated. Review of the MAR revealed that the direction for administration of the analgesic was "analgesic, give two tablets every four hours if needed for pain, may give one or two tablets", and it was different from the direction of the physician's order. Review of the MAR for a period of three months revealed the resident requested and was given the prescribed analgesic 45 times. However, the registered nursing staff did not indicate the quantity of the analgesic given, e.g., one or two tablets on the above mentioned occasions.

Interviews with staff #125 and #109 confirmed that the direction in the analgesic administration indicated on the MAR was different from the physician's order, and the MAR did not provide clear direction to registered nursing staff when administering the analgesic to the resident for pain control.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
There was no clear direction for the administration of the specified therapeutic treatment and related equipment for resident #006, and the dosage of the analgesic for resident #005.

The scope of the non-compliance is isolated to Resident #005 and #006.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.6(1)(c):
A Voluntary Plan of Correction (VPC) was previously issued for s.6(1)(c) during a Critical Incident Inspection on January 6, 2015, under inspection #2015_205129_0001.
A Written Notification (WN) was previously issued for s.6(1) during a Complaint Inspection on October 24, 2012, under inspection #2012_103193_0007. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Review of resident #005's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment on an identified date, indicated that the resident had minimal hearing difficulty when not in a quiet setting, and not using any communication devices.

During the course of inspection, the inspector observed the resident using a communicative device during communication with staff and the inspector. Interview with the resident revealed that the family brought the resident the device, approximately one month prior to the inspection, for the resident's impairment. The device was found effective for communication purposes.

Review of the resident's written plan of care failed to reveal information related to the resident's sensory impairment and the use of the communicative device as an effective intervention to facilitate the resident's hearing.

Interviews with staff #124, #129 and #109 confirmed that the resident started using the device a few weeks prior, and they found the device was effective in communication. Staff #109 further confirmed that the use of the device should be included in the resident's written plan of care. [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects

of care of the resident collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of resident #006's written plan of care stated to provide therapeutic treatment as per physician's order. Review of the physician's order for resident #006 stated to provide therapeutic treatment at a specified level continuously.

Interview with staff #132 revealed he/she had been applying the therapeutic treatment and setting the level for resident #006 on the days that he/she is assigned as the primary PSW caregiver for the resident. Interview with staff #109 and #111 revealed that it is the responsibility of the registered nursing staff to apply the therapeutic treatment as per physician's order. Neither staff #109 nor #111 was aware that the PSW was applying the therapeutic treatment equipment and setting the therapeutic treatment level for resident #006. [s. 6. (4) (b)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the physician's orders revealed resident #006 required continuous specified therapeutic treatment. The physician's order which has been in place since the resident's admission directed the staff to provide therapeutic treatment at a specified level continuously and up to three times of the specified level if needed. Review of the progress notes revealed on an identified date, the family of resident #006 attended a care conference after raising concerns about the resident's specified therapeutic treatment and equipment not being set up correctly and expressed concerns that the staff needed more training on the use of the equipment.

After the meeting on the same day, resident #006 was found by the service provider that the therapeutic treatment was not being provided to the resident.

Review of the progress notes for another identified date, revealed that resident #006 was found in the morning and the specified therapeutic treatment was not being provided.

Interview with staff #109 confirmed the resident's plan of care was not provided as specified in the plan and as ordered by the physician.

The severity of the non-compliance and the severity of the harm and risk of further harm

or risk is actual. The therapeutic treatment was not provided to Resident #006 as ordered.

The scope of the non-compliance is isolated to Resident #006.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.6(7):
A Voluntary Plan of Correction (VPC) was previously issued for s.6(7) during a Resident Quality Inspection on March 6, 2013, under inspection #2013_163189_0001. [s. 6. (7)]

5. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

a) Review of the health record revealed that resident #002 required specified therapeutic treatment at a specified level through specified medical device. Review of the resident's MAR indicated that the electric medical devices were to be checked six times daily to ensure functionality of the devices at 6 a.m., 7 a.m., 2 p.m., 3 p.m., 10 p.m. and 11p.m., with a start date of an identified date.

Review of the MAR documentation for two identified months, indicated seven times the scheduled checking the device were not documented.

Interviews with staff #108 and #109 confirmed that the provision of all interventions should be documented as required.

b) Review of the physician's order for resident #003 indicated the resident required two medical devices. Review of the resident's MAR indicated that the electric medical devices were to be checked six times daily to ensure functionality of the devices at 6 a.m., 7 a.m., 2 p.m., 3 p.m., 10 p.m. and 11p.m., with a start date of an identified date.

Review of the MAR documentation for two identified months indicated nine times of the scheduled checking the medical devices were not documented.

Interviews with staff #108 and #109 confirmed that the provision of all interventions should be documented as required.

c) Review of physician's order revealed that resident #006 requires specified therapeutic treatment and a device. The MAR documentation for an identified month indicated the

equipment checks were not documented on nine occasions.

There was no other indication through interview and record review that the equipment was checked for functionality. There was inconsistent documentation of the therapeutic treatment and the resident's condition which were ordered by the physician to be checked every four hours. The weights and vital signs summary record which was used to enter values for the specified condition was not consistently documented.

Interviews with staff #111 and #109 revealed they were unable to determine whether or not the equipment was checked for functionality or the resident's condition were checked because there was no documentation to support the provision of care.

d) Review of health record revealed that resident #004 was totally dependent on staff performing all activity daily livings (ADLs). Review of the written plan of care indicated the resident was to be turned and repositioned every two hours to prevent skin breakdown.

Interviews with staff #116 and #118 confirmed that the resident was scheduled to be turned and repositioned every two hours, and the PSWs were required to document on the Point of Care (POC) documentation system after each turning and repositioning.

Review of the POC record for a period of 10 weeks revealed 39 times of the scheduled turning and repositioning of the resident were not documented.

Interviews with staff #108 and #109 confirmed that staff were required to document on the POC after each turning and repositioning of the resident. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's policy titled, "Pain and Symptoms Management" (policy #: VII-G-30.10), revised January 2015, indicates that registered nursing staff are required to conduct a pain assessment using the electronic assessment template for all residents on admission and every three months. In addition the policy directs registered nursing staff to conduct weekly assessment for residents who have ongoing pain.

Interviews with staff #125 and #109 confirmed that registered nursing staff are required to conduct pain assessment using the clinically appropriate instrument (the electronic assessment template) for all residents on admission and every three months. The assessments are used for RAI-MDS coding purposes. If interventions are not effective, the resident should be assessed weekly using the clinically appropriate instrument.

Review of the health record for resident #005 revealed that the resident was prescribed analgesic by mouth as needed for pain with a specified start date. Review of the MAR and progress notes revealed the resident requested and was given eight doses of the analgesic in the following 10 days for pain.

Review of the progress notes and the physician's order revealed the resident requested a stronger analgesic for pain control on the eighth day after the analgesic was prescribed, and was prescribed one or two tablets of the same analgesic by mouth every four hours as needed 11 days after the analgesic was initiated.

Review of the health record revealed a pain assessment was completed for the resident using a clinically appropriate instrument on an identified date as part of the admission assessments. A subsequent pain assessment using a clinical appropriate instrument was not conducted until four months after the previous assessment, and 14 days after the follow-up inspection was initiated.

Interview with staff #109 confirmed that a pain assessment using a clinically appropriate instrument should have been conducted for resident #005 when she requested a stronger analgesic. [s. 52. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

Review of the home's policy titled, "Responsive Behaviours Management" (policy #: VII-F-10.20), revised January 2015, indicated that when a resident is exhibiting responsive behaviours, the registered nursing staff must document any measures to identify level of risk or triggers, and the effectiveness of a planned intervention on the individualized plan of care that is addressing specific responsive behaviours.

Review of resident #005's progress notes revealed that the resident exhibited responsive behaviours. Review of the resident's MDS assessment on an identified date revealed that the resident exhibited responsive behaviours. Review of the resident's written plan of care failed to reveal a section related to the resident's responsive behaviours and interventions.

Interviews with staff #123, #120 and #124 revealed the resident had responsive behaviours and could be easily altered by talking to the resident in a calm manner and providing rationales to the resident.

Interview with staff #109 confirmed he/she was aware of the resident's responsive behaviours, and the plan in referring the resident to Behaviour Support Ontario (BSO) was rejected by the family. Staff #109 further confirmed the resident's responsive behaviours and written strategies should be developed and included in the written plan of care. [s. 53. (1) 2.]

Issued on this 2nd day of December, 2015

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) :	STELLA NG (507)
Inspection No. / No de l'inspection :	2015_235507_0013
Log No. / Registre no:	T-2399-15/T-2400-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 10, 2015
Licensee / Titulaire de permis :	NORTH YORK GENERAL HOSPITAL 4001 LESLIE STREET, NORTH YORK, ON, M2K-1E1
LTC Home / Foyer de SLD :	SENIORS' HEALTH CENTRE 2 BUCHAN COURT, NORTH YORK, ON, M2J-5A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea McLister

To NORTH YORK GENERAL HOSPITAL, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall:

1) Develop and implement a process to identify and monitor the water temperature in random locations where residents have access to hot water once per shift,
2) provide training to staff in proper monitoring water temperature,
3) ensure the equipment used for monitoring hot water temperature is in good repair, and
4) develop and implement a process to take immediate action to reduce the water temperature in the event that is exceeds 49 degrees Celsius.

The licensee shall prepare, submit and implement a plan for complying with Orders 1-4 and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with.
This plan is to be submitted via email to inspector - stella.ng@ontario.ca by Novembe 30, 2015. The date for complying with Orders 1 - 4 shall not be later than December 31, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

As required under section 90(h) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Review of the home's policy titled, "Water Temperature Monitoring" (policy #: VII-H-10.26, revised September 2007) indicated the temperature of the hot water serving all bathtubs, showers and sinks used by residents must maintain at a temperature between 40 and 49 degrees Celsius, and will be monitored daily once per shift in random locations where residents have access to hot water. The policy further stated the procedure as followed:
i) Registered nursing staff must monitor hot water temperatures in random resident home areas (resident bathrooms, tub rooms, and public bathrooms) on each shift by running the hot water tap for five minutes, inserting the water temperature thermometer into the stream of water for 15 seconds then reading the temperature on the dial/ panel.
ii) Registered nursing staff must report all water temperatures above 49 degrees to maintenance personnel for adjustment and appropriate intervention and

document all reports and follow up in the "Comments" column of the monitoring form.
iii) Personal Support Workers (PSWs) must immediately report all water temperature over 49 degrees Celsius to the registered nursing staff.

Review of the "Resident Care Area Water Temperatures" records for three identified floors for a period of 11 weeks revealed that the water temperature in one or more resident rooms exceeding 49 degrees Celsius occurred almost daily. A total of 234 times of water temperature exceeding 49 degrees Celsius was recorded in 70 resident rooms in the above mentioned period. Among them, 25 records indicated the water temperature in random resident rooms exceeded 52 degrees Celsius, and the highest was 54.2 degrees Celsius recorded on an identified date in an identified resident room.

Interview with staff #116 revealed that his/her practice was to call the maintenance department to report any water temperature exceeding 49 degrees Celsius. Interview with staff #115 revealed that any maintenance request should be documented on the maintenance request logbook, including water temperatures exceeding 49 degree Celsius.

Review of the maintenance log books on the three identified floors failed to reveal that the maintenance staff were notified of hot water temperatures exceeding 49 degrees Celsius by the nursing staff as indicated in the home's "Water Temperature Monitoring" policy during the above mentioned period. An interview with staff #112 and #131 confirmed that maintenance department did not receive any report from the nursing staff, verbally or written, related to water temperatures exceeding 49 degree Celsius in the above mentioned 11 weeks' period. Since the maintenance department did not receive a report of water temperature exceeding 49 degrees Celsius, no immediate actions were taken to reduce the water temperature on those occasions. On an identified date, the concern related to no immediate action taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius was brought to the attention of staff #108 and the MWs, and staff #108 confirmed that no immediate actions were taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius in the above mentioned period as required under the Regulation. [s. 90. (2) (h)]

(507)

2. The licensee failed to ensure that the water temperature is monitored once per shift in random locations where residents have access to hot water.

As required under section 90(k) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

Review of the home's policy titled, "Water Temperature Monitoring" (policy #: VII-H-10.26, revised September 2007) indicated that the temperature of the hot water serving all bathtubs, showers and sinks used by residents are to be monitored daily once per shift in random locations where residents have access to hot water.

Review of the "Resident Care Area Water Temperatures" records for three identified floors for a period of 11 weeks revealed the hot water temperature was not monitored in any resident care areas of the home in 31 shifts.

Interview with staff #105 confirmed that the home was not using a computerized system to monitor the water temperature. Interview with staff #115 revealed that he/she was not aware of the hot water temperature monitoring required every shift, indicating that only the night shift was required to monitor the water temperature. Interview with staff #108 confirmed that the hot water temperature was not monitored once per shift in random locations where residents have access to hot water as required under the Regulation.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
The nursing staff did not notify the maintenance personnel when the water temperature exceeded 49 degrees Celsius, and preventing immediate action being implemented to respond to the elevated water temperature in the 11 weeks period. It was noted that on 234 occasions the water temperature exceeded 49 degrees Celsius in 70 resident rooms during the above mentioned period.

The scope of the non-compliance is a pattern. The frequency of water temperatures exceeding 49 degrees Celsius were noted to occur on three (3) resident home areas in the 11 weeks period. [s. 90. (2) (k)]

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_205129_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 87. (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations. 2007, c. 8, s. 87. (2).

Order / Ordre :

The licensee shall ensure that the emergency plans are updated and in writing, including specific roles and responsibilities of staff during the loss of essential services, specifically the loss of electric power.

Grounds / Motifs :

1. The licensee failed to ensure that there are emergency plans in place for the home that comply with the regulations, including measures for dealing with emergencies.

The licensee failed to comply with order CO#001, issued March 13, 2015, during the Critical Incident System Inspection #2015_205129_0001, with an order compliance date of June 1, 2015. The order directed the home to ensure all emergency plans are developed, updated, reviewed and tested
a) Annually: in addition to loss of one or more essential services and fire, situations involving a missing resident, medical emergencies and violent outbursts.
b) Once every three years: community disasters, bomb threat and chemical spills.

The order was issued with the following grounds:
1. There are no emergency plans in place that are home specific and available to staff at the time of inspection.
2. Interviews with the Administrator and Environmental Supervisor and record review confirmed that the home has not evaluated or updated the emergency

plans in the home to be home specific since the change in management from speciality Care to Leisureworld.
3. Interviews with the Administrator, director of care, Environmental Supervisor, the home's educator, and reception revealed that staff have not conducted tests in emergency plans annually or at least once every three years for identified emergencies as outlined in the Regulation.

In relation to emergency plans:
1. Under section 230(2) of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that all emergency plans are in writing.
2. Under section 230(5)4 of the Regulation 79/10 under the LTCHA, the licensee is required to ensure that the emergency plans address specific staff roles and responsibilities.

a) On an identified date, inspectors (#109 and #507) initiated the follow up inspection of the above Compliance Order. Review of the home`s emergency plans revealed the home's policy titled "Code Orange – Electrical Power Failure" (policy #: XVIII-H-10.40, revised June 2012) has not been updated since the order was issued on March 13, 2015. The written emergency plans concerning the loss of power during a power outage, related to power outages, specifically in relation to the roles and responsibilities of the staff working on two identified floors, were not updated.

Two days later, staff #106 provided the inspectors (#109 and #507) a copy of the home's policy titled "Code Orange – Electrical Power Failure" (policy #: XVIII-H-10.40, revised June 2012), with the following added to the policy in hand writing:
i) the current date was added to the current revision,
ii) once power is restored, staff shall immediately recheck and reconnect all electrical medical devices to the regular power sources, and
iii) a note "Levels I and II require hook up to generator electrical outlets located in hallways, identified by Red Dots when regular power outage occurs" was added to the policy.

The above mentioned revised (draft) policy failed to reveal the specific staff roles and responsibilities in connecting the electric medical devices to the emergency electrical outlets in maintaining functionality during power outage as required under section 230(5)4 of the Regulation 79/10 under the LTCHA.

b) Review of email communications between the home and Toronto Hydro-Electric System Limited and interview with staff #105 confirmed the home experienced three power outages in a period of five weeks and the duration of each occurrence was between five minutes and almost two hours.

Observations and interviews with staff #103, #116, #118, #121, #123, #119, #120, #104 and #115, revealed the following roles and responsibilities in relation to electric medical devices when power outage occurs:
i) Staff on first and second floors must use the extension cord connecting the electric medical devices to the emergency electrical outlet identified with a "red dot" located in the hallway, and
ii) staff on third and fourth floors must use the extension cord connecting the electric medical devices to the emergency electrical outlet identified with a "red dot" located in resident rooms.

c) Interviews with staff #106 and #109 confirmed that when power outage occurs, actions taken in connecting the electric medical devices to the emergency electrical outlets on first and second floors are different from actions taken on third and fourth floors due to the structure of the building. Staff #106 further confirmed there are no emergency electrical outlets in resident rooms on first and second floors; the emergency electrical outlet is located in the hallway.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
The home's emergency plan policy did not include the roles and responsibilities for staff who were working on the first and second floors when the power outage occurs, which was different from staff who were working on the third and fourth floors due to the building structure.

The scope of the non-compliance is wide-spread related to the emergency plan.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.87(2):
A Compliance Order (CO) was previously issued for s.87(2) during a Critical Incident Inspection on January 6, 2015, under inspection #2015_205129_0001. [s. 87. (2)] (507)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1) ensure that resident #005 and any other resident who require analgesic for pain control, have written plan of care which set out clear directions to staff who provide care to the resident, and
2) ensure that resident #006, and any other resident who require specified therapeutic treatment, have written plans of care which set out clear directions to staff who provide care to the residents.

The licensee shall prepare, submit and implement a plan for complying with Orders 1-2 and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with.
This plan is to be submitted via email to inspector - stella.ng@ontario.ca by November 30, 2015. The date for complying with Orders 1 - 2 shall not be later than December 31, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

a) Review of the physician's order for resident #006 revealed the doctor's order stated to provide specified therapeutic treatment continuously. The medication administration records (MAR) for a period of five weeks did not have directions

for the specified therapeutic treatment that was to be provided on a continuous basis in terms of the rational and the type of equipment and times that each of the specific equipment was used. The resident was using two different types of equipment at different times throughout the day.

Review of physician's order revealed that resident #006 required constant specified therapeutic treatment throughout the day and equipment to be applied during the night. Review of the MAR revealed there were no directions for the application of the specified therapeutic treatment and the equipment that was applied to the resident at night.

The written plan of care for resident #006 stated to maintain the specified therapeutic treatment as ordered by the physician and did not provide any directions for the type of equipment, the rationale and the level of the specified therapeutic treatment.

Interviews with staff #109 and #111 confirmed there were no clear directions to the staff and others who provide care to resident #006 as to the application of the specified therapeutic treatment and related equipment.

b) Review of resident #005's health records revealed that the resident was prescribed an analgesic two tablets by mouth as needed for pain with a start date of an identified date.

Review of the MAR and progress notes revealed the resident requested and was given eight doses of the analgesic in the following 10 days for pain. Review of the progress notes and the physician's order revealed that the resident requested a stronger analgesic for pain control on the eighth day after the analgesic was prescribed, and was prescribed one or two tablets of the same analgesic by mouth every four hours as needed 11 days after the analgesic was initiated. Review of the MAR revealed that the direction for administration of the analgesic was "analgesic, give two tablets every four hours if needed for pain, may give one or two tablets", and it was different from the direction of the physician's order. Review of the MAR for a period of three months revealed the resident requested and was given the prescribed analgesic 45 times. However, the registered nursing staff did not indicate the quantity of the analgesic given, e.g., one or two tablets on the above mentioned occasions.

Interviews with staff #125 and #109 confirmed that the direction in the analgesic

administration indicated on the MAR was different from the physician's order, and the MAR did not provide clear direction to registered nursing staff when administering the analgesic to the resident for pain control.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is potential.
There was no clear direction for the administration of the specified therapeutic treatment and related equipment for resident #006, and the dosage of the analgesic for resident #005.

The scope of the non-compliance is isolated to Resident #005 and #006.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.6(1)(c):
A Voluntary Plan of Correction (VPC) was previously issued for s.6(1)(c) during a Critical Incident Inspection on January 6, 2015, under inspection #2015_205129_0001.
A Written Notification (WN) was previously issued for s.6(1) during a Complaint Inspection on October 24, 2012, under inspection #2012_103193_0007. [s. 6. (1) (c)]

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in Resident #006's plan of care in relation to the provision of specified therapeutic treatment is provided as specified in the plan.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the physician's orders revealed resident #006 required continuous specified therapeutic treatment. The physician's order which has been in place since the resident's admission directed the staff to provide therapeutic treatment at a specified level continuously and up to three times of the specified level if needed. Review of the progress notes revealed on an identified date, the family of resident #006 attended a care conference after raising concerns about the resident's specified therapeutic treatment and equipment not being set up correctly and expressed concerns that the staff needed more training on the use of the equipment.

After the meeting on the same day, resident #006 was found by the service provider that the therapeutic treatment was not being provided to the resident.

Review of the progress notes for another identified date, revealed that resident #006 was found in the morning and the specified therapeutic treatment was not being provided.

Interview with staff #109 confirmed the resident's plan of care was not provided as specified in the plan and as ordered by the physician.

The severity of the non-compliance and the severity of the harm and risk of further harm or risk is actual. The therapeutic treatment was not provided to Resident #006 as ordered.

The scope of the non-compliance is isolated to Resident #006.

A review of the Compliance History revealed that the following non-compliance related to the Long-Term Care Homes Act, 2007, s.6(7):
A Voluntary Plan of Correction (VPC) was previously issued for s.6(7) during a Resident Quality Inspection on March 6, 2013, under inspection #2013_163189_0001. [s. 6. (7)]
(507)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 11, 2015

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 10th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG

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