Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2017	2017_378116_0006	017191-16, 017726-16, 019547-16, 021636-16, 021826-16, 022439-16, 023904-16, 027577-16, 028518-16, 032533-16, 034035-16, 035178-16, 003530-17, 003813-17, 005169-17, 005572-17, 007123-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

SARAN DANIEL-DODD (116), NICOLE RANGER (189), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 27, 28, 29, 30, 31 & April 3, 4, 5, 6, 7, 10, 11, 12, 13, 2017.

The following complaint inspection was conducted concurrently with this inspection:
Log #004263-17 related to injury of unknown cause

The following critical incident system (CIS) inspections were conducted concurrently with this inspection:
Log #'s: 017191-16, 022439-16, 027577-16, 035178-16, 005572-17 related to resident to resident abuse,
Log #'s: 023904-16, 028518-16, 032533-16 related to staff to resident abuse
Log #s: 019547-16, 034035-16 related to improper treatment
Log #'s: 021636-16, 007123-17 related to falls prevention
Log #'s:017726-16, 021826-16, 003530-17, 003813-17, 005167-17 related to injury of unknown cause

Critical Incident System Log #032533-16 was conducted under this inspection report #2017_378116_0006 which was inspected concurrently with Follow up inspection #2017_659189_0006. An area of non-compliance related to s. 19 (1) is being issued under the follow up inspection report.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (E.D.), Director of Care (DOC), Associate Director of Care (ADOC), clinical consultant, minimum data set resident assessment instrument (MDS-RAI) coordinator, registered staff members, personal support workers (PSW), union steward, physiotherapist, Substitute Decision Maker(s) (SDM), residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **9 WN(s)**
- **7 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident and/or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, the home submitted a critical incident system report (CIS) to the Director reporting an incident of improper or incompetent treatment of care to resident #016 that resulted in harm. The CIS read as follows:

On an identified date, resident #016 reported to RN staff #122 that PSW staff #110 was providing care in an identified manner which resulted in harm.

Interviews held with PSW #113 indicated that the concerns were brought forward to RN #122 who reported the concerns to the DOC via email on the same date of the incident. Record review and an interview held with the DOC confirmed that the suspicion(s) of improper care or incompetent treatment of resident #001 was not immediately reported to the Director.

The CIS was conducted under this inspection report #2017_378116_0006 which was inspected concurrently with follow up inspection # 2017_659189_0006. An area of non-compliance related to s. 19 (1) is being issued under the follow up inspection report. [s. 24. (1)]

2. On an identified date, the home submitted a CIS to the Director reporting an incident of resident to resident abuse which resulted in harm to resident #004. The CIS indicated that an identified individual raised concern regarding the identified harm and requested a further investigation.

Review of progress notes for an identified date, revealed that an identified individual initially brought the concerns forward to RN #105. Interviews held with the identified individual and RN #105 indicated that the individual requested an investigation to be conducted to rule out abuse of the resident by a staff member or another resident.

Record review revealed and an interview held with RN # 105 indicated that the concerns were brought forward to the DOC on an identified date.
An interview held with the DOC and the E.D. revealed that the suspicion(s) of improper care and/or abuse of resident #004 were not immediately reported to the Director. [s. 24. (1)]

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 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).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to 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): An incident that caused an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

On an identified date, the home submitted a CIS related to an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #007's progress notes revealed that the resident was admitted to the hospital on an identified date, with significant injuries, and a confirmed diagnosis. An interview with the DOC revealed that he/she was made aware of the resident's diagnosis upon transfer to the hospital, however he/she was awaiting written confirmation of the diagnosis which was received three days later. The DOC reported that the MOHLTC was

notified when the home initiated the report three days later. [s. 107. (3) 4.]

2. The licensee has failed to ensure that where an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, has the licensee:
a) contacted the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident.

On an identified date, the home submitted a CIS to the Director reporting an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change to the resident's health status. The CIS read as follows:

On an identified date, resident #013 was transferred to the hospital for further assessment. Resident had a reported incident on an identified date.

Record review of resident #013's progress notes on an identified date, revealed that the resident had an unwitnessed incident in an identified location. Further review of the progress notes indicated that on a identified date, a skin impairment was noted to a disclosed location of resident #013's body. Interviews held with RN staff #131 revealed that identified individuals were notified of the skin impairment however, the skin impairment was not reported to the physician for further direction.

Record review revealed that the resident sustained an injury that resulted in a significant change in health status.

Review of the resident's health record revealed and interviews held with RN staff #131 and the DOC confirmed that the home failed to contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and they did not inform the Director of the incident within three business days after becoming aware that the injury resulted in a significant change in the resident's health condition. [s. 107. (3.1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted:
- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity
- every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs

On an identified date, the home submitted a CIS reporting an allegation of staff to resident abuse. The CIS read as follows: On an identified date, an identified individual reported to the DOC that he/she witnessed abuse from a staff member of the home towards a resident.

An interview with the identified individual reported that on an identified date, he/she was in an identified location with another resident, when he/she observed RPN #114 approach resident #001. RPN #114 approached the resident with his/her identified treatment, for which the resident refused. RPN #114 acted inappropriately to address the

resident and left the identified location.

During an interview with RPN #114, he/she denied that the incident occurred however, the DOC reported after review of the camera surveillance and witnessed report from the identified individual, the home confirmed that the incident occurred and RPN #114 was disciplined. The DOC confirmed that the action of the RPN was inappropriate and did not treat the resident with dignity and respect. [s. 3. (1) 1.]

2. On an identified date, the inspector entered an identified unit and observed the door to an identified room to be open. PSW staff #'s 134 and #145 were present in the hallway adjacent to the identified room. The inspector entered the identified room and observed the door to the washroom enclosed open. The inspector observed program aide staff #136 assisting PSW staff #135 transfer resident #017 to the toilet. Resident #017 was undressed from the waist down. Resident #017 appeared to be exhibiting responsive behaviours and PSW #135 made an inappropriate statement.

Upon initial interview with program aide #136 he/she denied assisting the resident. Further interview revealed that PSW #135 requested the assistance of program aide #136. Program aide #136 further stated that he/she is not trained to assist with resident transfers and that PSW #135 made the inappropriate statement as the resident was resisting assistance and would have fallen. Program aide #136 indicated that the door to the identified room and the washroom enclosed should have been closed during care.

An interview held with PSW #135 revealed being aware that resident #017 requires two persons for transfers/toileting and requested the assistance of program aide #136 as direct care staff were unavailable and the resident would have experienced a fall. PSW #135 denied making the inappropriate statement. Further interview revealed that the door to both the identified room and washroom enclosed should be closed at all times when rendering care.

Interviews with PSW #135, program aide #136, DOC and the clinical consultant confirmed that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was not upheld. [s. 3. (1) 8.]

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 following rights of residents are fully communicated and promoted:

- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and,
- Every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #4: 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. (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. (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 has failed to ensure that the plan of care sets out clear directions to staff and others who provided direct care to the resident.

The home submitted a CIS report on an identified date, related to a fall resulting in an injury.

During an observation conducted on an identified date, it was noted that resident #022 had identified devices attached to the bed and within the bedroom, without the resident in bed. At an identified time, the inspector observed the resident in an identified mobility device in a disclosed area, and had an identified device applied to an identified article.

Record review of resident #022's Falls Risk Assessment Tool (FRAT) for an identified date, indicated he/she was at an identified risk for falls. Record review of resident #022's written plan of care completed on an identified date, did not indicate information regarding the use of identified devices.

Interview with RPN #115 confirmed that resident #022's written plan of care did not include the identified devices and interventions, and that the written plan of care did not set out clear directions to staff.

Interview with the DOC confirmed that resident #022's written plan of care did not set out clear directions to staff as it did not include the fall prevention interventions that were in place for the resident. [s. 6. (1) (c)]

2. The home submitted four identified CIS reports to the Ministry of Health and Long-Term Care (MOHLTC) related to resident to resident abuse, unlawful conduct that resulted in harm or risk of harm to a resident, incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #023's written plan of care completed on an identified date, indicated under an identified section that he/she required care by two staff, whereas in other identified sections indicated he/she required one person for assistance.

Interview with RPN #127, who was the assigned one on one staff for resident #023, stated the resident required one staff for personal care unless he/she was exhibiting responsive behaviours, then two staff would provide the care.

Interview with RPN #119 stated resident #023 required two staff for care when he/she exhibited identified behaviours. The RPN confirmed that the resident's written plan of care did not provide clear directions to staff.

Interview with the DOC acknowledged resident #023's written plan of care did not set out clear directions to staff, and that the home's expectation was to ensure that the written plan of care was clear and concise for staff. [s. 6. (1) (c)]

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

On an identified date, the home submitted a CIS report to the Director reporting an incident of improper/incompetent treatment of a resident that resulted in harm to resident #016. The CIS read as follows:

On an identified date, resident #016 reported to RN staff #122 that PSW staff #110 was providing care in an identified manner which resulted in harm.

The written plan of care for resident #016 stated that the resident required total assistance of two staff.

An interview held with PSW #110 revealed that on an identified date, he/she proceeded to assist resident #016 without the assistance of another staff member. PSW #110 indicated that he/she has always assisted the resident in this manner since the resident's admission to the home. Further interview with PSW #110 and the DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

4. On an identified date, the home submitted a CIS report reporting an allegation of resident to resident abuse. The CIS read as follows:
On an identified date, an identified interaction occurred between resident #002 and resident #003, causing resident #003 to fall. Resident #002 was observed to continue to exhibit identified responsive behaviours towards resident #003.

Record review and staff interview revealed that resident #002 has a history of identified responsive behaviours towards staff and co residents', and the home has implemented one to one monitoring for the resident. Review of the written plan of care for an identified date, directs PSW staff to complete an established frequency of checks when there is no

one to one present.

Record review revealed that at the time of the incident, resident #002 was not receiving one to one monitoring. Interview with PSW #101 revealed that on the day of the incident, he/she was providing care in another room, when he/she heard a loud noise in an identified area, and when he/she came to the identified area, he/she found resident #003 in an identified manner and resident #002 also in an identified manner. PSW #101 reported that he/she did not observe any other staff at the time, so he/she went to call the nurse to come and assess the resident. Interview with PSW #104 who was assigned to provide care to the resident, reported that he/she did not observe the incident as he/she was not located in the area. When asked if he/she provided the required frequency of monitoring on resident #002, PSW #104 reported he/she did not and it is the responsibility of the registered staff to complete. A review of the identified date, PSW documentation for task of monitoring revealed that the required frequency of monitoring for five specified time periods was documented at the same time by PSW #104. A review of the documentation with the DOC revealed that the care set out in the plan of care was not provided to resident #002. [s. 6. (7)]

5. The licensee has failed to ensure that the plan of care was reviewed and revised at any other time when the resident's care needs changed.

The home submitted a CIS report on an identified date, to the Director reporting a fall that resulted in an injury.

During an observation conducted during the inspection, it was noted that resident #022 had an identified device applied to the bed and other identified equipment in his/her bedroom, without the resident in bed. At an identified time, the inspector observed the resident in an identified mobility device, and had an identified device applied to an identified article.

Record review of resident #022's Falls Risk Assessment Tool (FRAT) for an identified date, indicated he/she was at an identified risk for falls. Record review of resident #022's written plan of care completed on an identified date, did not indicate information regarding the use of identified devices.

Interviews with PSWs #108, #116 and RPNs #114 and #115 confirmed that specified fall prevention interventions were in place for resident #022. The RPNs confirmed that the resident's written plan of care did not include the identified fall prevention interventions

that were currently in place. Both registered staff further indicated that it was the nurse's responsibility to update the written plan of care when the resident's care needs changed. RPNs #114 and #115 confirmed that resident #022's written plan of care was not reviewed and revised when his/her care needs changed.

Interview with the DOC acknowledged that resident #022's written plan of care was not reviewed and revised when his/her care needs changed, and that the home's expectation was for registered staff to review and revise the resident's plan of care and include changes to the plan that needed to be implemented. [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 the following in regards to the plan of care for all residents:

- sets out clear directions to staff and others who provided direct care to the resident
- the care set out in the plan of care is provided to the resident as specified in the plan
-the plan of care is reviewed and revised at any other time when a resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy entitled "Falls Prevention and Injury Reduction" states the following:

- if a fall is unwitnessed or the resident has hit their head, a neurological assessment is initiated, and the resident is monitored for 72 hours.
- follow the frequency of observation as per the neurological flow sheet or as determined by the physician or regional requirement. Notify the physician if there is any sudden change.

On an identified date, resident #013 had an unwitnessed fall within an identified location. At the time of the fall there were no signs and/or symptoms of injury or pain. Head injury routine was initiated as per the home's policy. On an identified date, a skin impairment was observed to a location on the resident's body.

Review of the resident's health record completed for a specified period, revealed that the head injury routine was not conducted for two identified periods.

Interviews held with registered staff #'s 109, 129, 131 and the DOC confirmed that the homes fall prevention and injury reduction policy was not complied with. [s. 8. (1)]

2. On an identified date, the home submitted a CIS reporting an improper/incompetent treatment of a resident. The CIS states that resident #005 reported that he/she sustained a skin impairment due to an inappropriate transfer.

Record review and staff interview revealed that on an identified date, resident #005 reported to PSW #139 that he/she developed a skin impairment as he/she was toileted by staff without the use of a require device. Interview with PSW #139 revealed that the resident reported details of the incident to him/her.

A review of the home's policy entitled " Resident Non-Abuse", directs the staff that an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the home's ED/designate.

Record review of the home's investigation related to the incident, revealed that the DOC

interviewed the PSW staff who worked specified shifts on identified dates. Interview with the DOC confirmed that he/she did not interview the staff who worked a specific shift on the identified dates, nor did the DOC interview PSW #139 to inquire what the resident reported to him/her. The DOC confirmed that a thorough investigation into the incident was not conducted. [s. 8. (1)]

3. On an identified date, the home submitted a CIS, related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. The CIS reports that on an identified date, resident #007 sustained a witnessed fall resulting in hospitalization.

Record review and staff interview revealed that during a specified shift on an identified date, agency PSW #143 was assigned to provide one to one care for resident #007. Interview with agency PSW #143 revealed that around a specified time, he/she assisted the resident with care, then brought the resident out of his/her room and around the unit for a short period of time. PSW #143 reported that he/she took the resident around the unit several times. PSW #143 reported that as he/she returned the resident back to the room the final time, resident #007 transferred himself/herself unassisted from an identified mobility device into the bed. PSW #143 reported that the resident stayed in bed for a short period of time, then stated that he/she wanted to go back onto the unit again. PSW #143 reported that the resident got out of the bed when suddenly, the resident lost his/her balance causing a fall. An identified area of the resident's body made contact with an identified item. PSW #143 reported that the resident sustained a sudden change of health status, so he/she repositioned the resident, then immediately ran to inform RN #109 of the incident.

Interview with RN #109 revealed that he/she was informed by PSW #143 that the resident had fallen. RN #109 revealed that as he/she entered into resident #007's room, he/she observed the resident's condition. RN #109 reported that he/she observed agency PSW #143 in an identified position and moving the resident in an identified manner. RN #109 reported that he/she instructed the PSW to stop moving the resident in the identified manner, then went back to the nursing station and called 911.

A review of the home's policy entitled "LTC – Post Fall Management procedure, effective August 31, 2016, directs the staff that if a resident has fallen the resident should not be moved, except to avoid further hazards or injury. The procedure also directs the staff that vital signs are to be taken.

Interview with RN #109 revealed although the resident was found with a significant change in health status, the RN confirmed that he/she did not take the resident's vital signs, nor assess the change in health status to determine if treatment can provided.

A review of the home's video surveillance of the incident, and confirmed from the agency PSW #143 who was present at the time of the incident, revealed that RN #109 quickly observed the resident in the room, went to the nursing station to call 911, but did not return back to the room to assess or treat the resident, or take the resident's vital signs. Interview with the DOC, who reviewed the video surveillance with the inspector, confirmed that RN #109 did not follow the home's policy related to post fall management of the resident. [s. 8. (1) (a),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 following plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with:

- Fall Prevention and Injury Reduction (#Care5-O10.02 & Care5-O10.03)
- Resident Non-Abuse – Ontario, LP-C-20-ON
- LTC – Post Fall Management procedure
, to be implemented voluntarily.

WN #6: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any potential behavioural triggers and variations in resident functioning at different times of the day.

The home submitted four CIS reports on separate dates to the MOHLTC related to resident to resident abuse, unlawful conduct that resulted in harm/risk of harm to resident, incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #023's progress notes revealed he/she had a history of exhibiting identified behaviours towards the staff and the other residents on the unit. Review of resident #023's progress note for an identified date, indicated that an identified gender of staff had been a behavioural trigger for the resident. Review of resident #023's record indicated a recommendation to assign a specific gender of staff for one on one care as resident #023 responded better to that gender. Review of resident #023's written plan of care completed on an identified date and the kardex, did not indicate the above-mentioned behavioural trigger.

Interviews with PSW #101, RPNs #119, and #127 confirmed that a specified gender of staff were identified to trigger resident #023's identified behaviours. They further stated that the resident has displayed identified behaviours to the specified gender of staff. RPN #119 further indicated that the above-mentioned behavioural trigger should have been

included in the resident's plan of care.

Interview with the DOC stated that the home's expectation was to include the resident's behavioural trigger in his/her plan of care. [s. 26. (3) 5.]

2. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

Resident #013 was admitted to the home on an identified date with confirmed diagnoses. Review of progress notes for an identified date, and an interview held with the physiotherapist (PT) indicated that the resident was assessed for risk of falls and deemed with an identified risk due to previous identified medical condition(s).

Review of the written plan of care created on an identified date, and the current written plan of care does not identify the resident's fall risk and associated interventions developed to minimize the risk of falls.

Interviews held with RAI-MDS coordinator, PT and the DOC confirmed that the plan of care for resident #013 is not based on an interdisciplinary assessment with respect to the resident's health condition including risk of falls and other special needs. [s. 26. (3) 10.]

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 the following with respect to the residents:
- mood and behaviour patterns, including any potential behavioural triggers and variations in resident functioning at different times of the day
- health conditions including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

The written plan of care for resident #015 identifies that the resident is incontinent and requires the use of incontinence brief to remain clean and comfortable. Resident #015 requires total assistance for toileting.

During an interview with an identified individual, it was identified that the resident was not afforded adequate continence care changes on a specified date.

Interviews held with PSW staff member #s 101, #124, #133 and #134 indicated that the resident usually requires an identified number of incontinent changes during a specified shift.

A review of the home's investigative notes revealed and interviews held with PSW staff #124 and the DOC confirmed that on an identified date, resident #015 did not receive sufficient changes to remain clean, dry and comfortable. PSW staff #124 could not provide an explanation related to the insufficient changes. PSW staff #124 was disciplined as a result of the incident. [s. 51. (2) (g)]

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 who requires continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #8: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

On an identified date, the licensee submitted a CIS, related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. The CIS reports that on an identified date, resident #007 sustained a witnessed fall resulting in hospitalization.

Record review and staff interview revealed that during a specified shift on an identified date, agency PSW #143 was assigned to provide one to one care for resident #007. Interview with agency PSW #143 revealed that at an approximate time, he/she assisted the resident with care, then brought the resident out of his/her room and around the unit for short period of time. PSW #143 reported that he/she brought the resident back and forth from his/her room to the unit several times. PSW #143 reported that as he/she returned the resident back to the room the final time, resident #007 transferred himself/herself unassisted from an identified mobility device into the bed. PSW #143 reported that the resident stayed in bed for a short period of time, then stated that he/she wanted to go back onto the unit again. PSW #143 reported that the resident got out of the bed when suddenly, the resident lost his/her balance and fell, hitting an identified area of his/her body against an identified item. PSW #143 reported that the resident sustained a sudden change in health status, so he/she moved the resident, then immediately ran to inform RN #109 of the incident.

Interview with the DOC revealed that after the incident that occurred on the identified date, PSW #143 was no longer assigned shifts at the home.

A review of the home's training records revealed and interview with the DOC confirmed that PSW #143 (persons who work at the home pursuant to a contract or agreement

between the licensee and an employment agency did not receive training or orientation on the home's policy and procedures, prior to performing assigned responsibilities in the home. [s. 76. (2)]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- mental health issues, including caring for persons with dementia
- behaviour management.

For the purposes of subsection (1), a staff member who is agency staff, as that term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home.

An interview with an identified individual revealed that the utilization of agency staff members is high upon an identified unit in the home. The identified individual expressed that agency staff do not receive training from the home in relation to caring for persons with conditions identified above.

A review of the home's training records revealed and interviews held with the DOC and nursing supervisor(s) of the agencies utilized by the home confirmed that PSWs (persons who work at the home pursuant to a contract or agreement between the licensee and an employment agency) did not receive training prior to performing their responsibilities and as a condition of continuing to have contact with residents. [s. 76. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

On an identified date, the inspector observed a medication cart located on an identified unit to be unlocked and unsupervised. The inspector was able to open the cart and access the contents inside. Pre-poured medications were noted for resident #'s 011 and 018. RN staff #106, assigned to the medication cart was located in an area where the medication was not visible. RN staff #106 returned to the medication cart at an identified time and confirmed that the pre-poured medications do not belong to an identified category of medications. RN staff #106 further confirmed that the medication cart should be locked at all times when unsupervised. [s. 130. 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 ensure that steps are taken to ensure the security of the drug supply, including the following:
- all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 31st day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAN DANIEL-DODD (116), NICOLE RANGER (189), ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2017_378116_0006
Log No. / Registre no:	017191-16, 017726-16, 019547-16, 021636-16, 021826-16, 022439-16, 023904-16, 027577-16, 028518-16, 032533-16, 034035-16, 035178-16, 003530-17, 003813-17, 005169-17, 005572-17, 007123-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 29, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	SHERWOOD COURT LONG TERM CARE CENTRE 300 Ravineview Drive, Maple, ON, L6A-3P8
	Jasdeep Grewal

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

Upon receipt of this order the licensee shall,
1. Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks:
2. Review the home's current policy on reporting certain matters to the Director in relation to s.24 and delineate the responsible person(s) to report such matters to the Director.
3. Provide re-education and training to all staff and management in the home on the home's policy on reporting certain matters to the Director under s. 24.and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The plan is to be submitted to Saran.DanielDodd@ontario.ca by June 6, 2017

Grounds / Motifs :

1. On an identified date, the home submitted a CIS to the Director reporting an incident of resident to resident abuse which resulted in harm to resident #004. The CIS indicated that an identified individual raised concern regarding the identified harm and requested a further investigation.

Review of progress notes for an identified date, revealed that an identified individual initially brought the concerns forward to RN #105. Interviews held with

the identified individual and RN #105 indicated that the individual requested an investigation to be conducted to rule out abuse of the resident by a staff member or another resident.

Record review revealed and an interview held with RN # 105 indicated that the concerns were brought forward to the DOC on an identified date.
An interview held with the DOC and the E.D. revealed that the suspicion(s) of improper care and/or abuse of resident #004 were not immediately reported to the Director. [s. 24. (1)]

(116)

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident and/or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, the home submitted a critical incident system report (CIS) to the Director reporting an incident of improper or incompetent treatment of care to resident #016 that resulted in harm. The CIS read as follows:

On an identified date, resident #016 reported to RN staff #122 that PSW staff #110 was providing care in an identified manner which resulted in harm.

Interviews held with PSW #113 indicated that the concerns were brought forward to RN #122 who reported the concerns to the DOC via email on the same date of the incident. Record review and an interview held with the DOC confirmed that the suspicion(s) of improper care or incompetent treatment of resident #001 was not immediately reported to the Director.

The CIS was conducted under this inspection report #2017_378116_0006 which was inspected concurrently with follow up inspection #2017_659189_0006. An area of non-compliance related to s. 19 (1) is being issued under the follow up inspection report. [s. 24. (1)]

The severity of harm and risk of harm to residents arising from the non compliance resulted in actual harm. The scope of harm and risk of harm from the non compliance is isolated. The home has an ongoing non-compliance with a voluntary plan of correction issued under s.24.

(116)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

Upon receipt of this order the licensee shall,

1. Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks:
2. Review the home's current policy on reporting requirements for critical incidents to the Director in relation to s. 107 and determine the responsible person(s) to report specified matters to the Director.
3. Provide re-education and training to all staff and management in the home on the home's policy on reporting critical incidents under s. 107 and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.
4. The re-education and training must include a review of the reporting time frames outlined under s. 107 and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The plan is to be submitted to Saran.DanielDodd@ontario.ca by June 6, 2017

Grounds / Motifs :

1. The licensee has failed to 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): An incident that caused an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

On an identified date, the home submitted a CIS related to an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #007's progress notes revealed that the resident was admitted to the hospital on an identified date, with significant injuries, and a confirmed diagnosis. An interview with the DOC revealed that he/she was made aware of the resident's diagnosis upon transfer to the hospital, however he/she was awaiting written confirmation of the diagnosis which was received three days later. The DOC reported that the MOHLTC was notified when the home initiated the report three days later. [s. 107. (3) 4.]

The severity of harm and risk of harm to residents arising from the non compliance resulted in actual harm. The scope of harm and risk of harm from the non compliance is isolated. The home has an ongoing non-compliance with a voluntary plan of correction issued under s.107(3).

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

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