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 sions 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
Jun 3, 2016	2016_322156_0006	010694-16	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

CAROL POLCZ (156), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 19, 20, 21, 22, 25, 26, 27, 28, 29, May 3, 4, 2016

The following inspections were completed concurrently with the RQI:
Complaints
010104-15 related to duty to protect and dining service
011313-15 related to pain management, duty to protect and falls management
032147-15 related to medication administration, transferring and positioning and plan of care

Critical Incident Reports

028211-15 related to falls and plan of care
020702-15 related to prevention of abuse and neglect
020997-15 related to prevention of abuse and neglect - included 012970-16, 012980-16 and 012984-16

Follow ups:

009698-15 related to plan of care
009699-15 related to plan of care
009721-15 related to lighting

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing and Personal Care - Administration, Director of Nursing and Personal Care - Clinical, Business Manager, Social Worker, Environmental Services Manager, Food Services Manager (FSM), Quality Improvement Lead, Staff Development Coordinator, Maintenance Managers, Corporate Nurse Clinician, Infection Prevention and Control Lead, Wound Care Nurse personal support workers (PSWs), registered nursing staff, laundry aides, dietary aides, residents and families

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **8 VPC(s)**
- **3 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
O.Reg 79/10 s. 18.	CO #001	2014_189120_0034	536
LTCHA, 2007 s. 6. (10)	CO #002	2015_188168_0010	156
LTCHA, 2007 s. 6. (7)	CO #001	2015_188168_0010	156

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and to ensure that residents were not neglected by the licensee or staff.

The records of residents #032 and #033 were reviewed. It was noted that on an identified date in August, 2015 resident #033 inappropriately touched resident #032. Resident #032 called resident #033 a name.
The records of residents #031 and #033 were reviewed. It was noted that on an identified date in September, 2015 a staff member witnessed resident #033 inappropriately touching resident #031.
The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.
The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on another identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.
The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on an identified date in August, 2015 a staff member observed resident #033 inappropriately touching resident #044.

The home's records were reviewed including Critical Incident (CI) reports: #2739-000051-15; #2739-000058-15; #2739-000016-16; #2739-000017-16 and 2739-000018-16 and they included information as above.

The Director of Care (DOC) was interviewed and confirmed information as included in the residents' records and the home's records. The DOC confirmed that residents #031, #032 and #044 had cognitive impairments and did not consent to the inappropriate touching by resident #033.

The licensee failed to protect residents #031, #032 and #044 from abuse by resident #044.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #008 was observed to have a quarter rail in the "down" or engaged position on the right side of the bed and a quarter rail in the "up" position on the left hand side of the bed throughout the inspection. The resident reported that both bed rails were used; however, the plan of care for this resident indicated that only one bed rail was used as a positioning device.
Interview with registered staff #200 on April 22, 2016 reported that only the rail that was in the "down" position is assessed for all residents. A review of the home's "Interdisciplinary Restraint/PASD Assessment and Consent" completed by registered staff #200 dated March 6, 2016 had the "PASD bed rails" box checked off but the assessment was not completed.
Neither bed rail was assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #200 on April 22, 2016 and the Director of Care (DOC) on April 26, 2016.

B) Resident #005 was observed to have a quarter rail in the "down" or engaged position on the left side of the bed and a quarter rail in the "up" position on the right hand side of the bed throughout the inspection. The plan of care for this resident indicated that one bed rail was used as a positioning device.
A review of the home's "Interdisciplinary Restraint/PASD Assessment and Consent" for

this resident completed had the "PASD bed rails" box checked off but the assessment was not completed.
Neither bed rail was assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with the Director of Care (DOC) on April 26, 2016.

C) On April 26, 2016, The DOC confirmed that approximately 80% of the beds in the home had quarter rails in the "up" position as part of the bed systems. The rails were either 'up' or 'down/engaged'. It was confirmed that residents with these rails in the "up" position had not been assessed and his or her bed systems evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the residents. [s. 15. (1) (a)]

2. D) The record of resident #034 was reviewed and it was noted that on May 20, 2015 the resident was transferred from an identified floor (A) to another identified floor (B). While on floor A, the resident used two bed rails and wedges. When the resident moved to floor B they were placed in a new bed with bed rails and wedges as they had been using on floor A. A bed rail assessment dated in May 20, 2015 was not found in the resident's record. The resident fell several times and a bed rail assessment was completed on May 31, 2015.
The DOC was interviewed and confirmed that a bed rail assessment completed on November 19, 2014 and May 31, 2015 were the only bed rail assessments available. The DOC confirmed that a bed rail assessment was not completed on May 20, 2015 when the resident initially moved into a new bed on the second floor. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A) On identified dates in January, June and September, 2015, resident #021 had falls each one resulting in injury. The fall that occurred in September, 2015, resulted in the resident being transferred to hospital two days later. The resident was declared palliative and passed away the same day. A review of the clinical record identified that the three falls all occurred between the hours of 0215 hrs and 0700 hrs. Each of these falls occurred when the resident, who was visually impaired, was attempting to go to the bathroom. The plan of care for resident #021, identified that the resident required assistance for the physical process of toileting related to impaired vision and pain. The plan of care also stated, that the resident was to be assisted to the washroom between 0100 to 0200 hrs and 0500 to 0600 hrs, as the resident may attempt to self toilet. A review of the flow sheets for the dates of the falls, identified that on the three nights that the falls occurred, the documentation for each of these nights only reflected that the resident was toileted one out of two times each shift or 50% (percent) of the toileting times. Personal Support Worker (PSW) #102 reported that the resident would often refuse. The PSW also confirmed that the refusals were not documented. The home did not ensure that the interventions in place for resident #021 through their falls prevention program were reassessed, and the resident's responses to interventions documented.

A review of the risk management incident reports for the January, June and September, 2015, were completed. The homes expectation of the registered staff when completing the incident reports, was to complete all sections. In each of the three falls, resident #021 sustained injury. One of the sections to be completed was pain. The registered staff were to ask the resident who was able to respond what their pain level is on a scale of one to ten. On review of the risk management incident reports for the three falls, it was noted that on the January, 2015 incident report, that the resident was asked if they had pain by the registered staff. The resident identified that their pain was nine out of ten. There was no further evidence in the clinical record that any further investigation was done to address the resident's complaints of pain. Staff #206 who completed the incident report, confirmed they had not followed through on the resident's pain. For the fall which occurred in September, 2015, there was no evidence in the clinical record that the resident was asked if they had pain. Staff #206 who completed the incident report confirmed they had not completed the pain section. The home did not ensure that

assessments and the resident's responses to interventions were documented.

2. B) The records of residents #033 and #044 were reviewed including the progress notes and it was noted in the record of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044. No documentation related to the above abuse incident was found in the record of resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the progress notes of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately sexually touching resident #044. No documentation related to the above sexual abuse incident was found in the record of resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the progress notes of resident #033 that on an identified date in August, 2015 a staff member observed resident #033 inappropriately touching resident #044. No documentation related to the above abuse incident was found in the record of resident #044.

The DOC was interviewed and reported that there were no progress notes documented in the record of resident #044 from specified dates in July, 2015 and that there was no documentation in the resident's record related to the abuse incident of August, 2015.

The DOC confirmed that any actions taken with respect to resident #044 in relation to the three incidents above including assessments, reassessments, interventions and the resident's responses to interventions were not documented.

3. C) The record of resident #007 who had a wound on an identified area was reviewed including the progress notes and "Pixalere" wound record. There was no documentation of the wound being assessed between March and April, 2016.

The home's Wound Care Nurse was interviewed and confirmed that there was no documentation available of the wound assessments for resident #007 from March to April , 2016.

Additional Required Actions:

CO # - 002 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) Resident #008 was noted to have had a fall on an identified date in March, 2016 while trying to transfer without assistance. A "Head to Toe" assessment was done, vitals were taken and Head Injury Routine was initiated. The clinical record was reviewed and a post fall assessment using a clinically appropriate assessment instrument was not found.

Interview with the DOC and registered staff #200 on April 22, 2016 confirmed that a post fall assessment was not completed.

B) The record of resident #034 was reviewed and it was noted that on an identified date in May, 2015 the resident had a fall. There was no evidence that a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls found in the resident's record.

The DOC was interviewed and confirmed that a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

The home's policy Food and Nutritional Services Manual - Serving Temperatures FNSMS140 dated January 29, 2013 indicated that "hot foods shall be served to residents at a minimum of 60C and cold foods shall be served at a maximum of 5C, excluding tube feedings. Foods must not be served in the danger zone of 5-60C or 40-140F. Prepared food is to be maintained at temperatures that meet the Ministry of Health and Public Health standards. The following are the recommended serving temperatures: broth, soups and hot beverages 82-88C (170-190F), meat, portioned for serving 60-71C (140-160F), creamed soups, sauces, casseroles 65-75C (149-167F), potatoes, vegetables 60-65C (140-149F), chilled food and beverages 4-12C (39-54F)."

During the dining observation on April 27, 2016, food temperatures were taken at the beginning of second sitting on second floor. Dietary staff #400 reported that one steam well on the steam table was not working effectively for the past week or so and had been reported to management. This steam well contained the regular texture chicken fingers which were probed at 120F and regular/minced vegetarian chili which was probed at 143F. After discussion with the inspector, the dietary staff proceeded to change the pan of hot food items with one of cold food items in this well.
The remaining food items were probed and several items were not found to be at safe temperatures: puree chili was probed at 130F, corn chowder was probed at 130F and puree corn chowder was probed at 142F, minced chicken fingers was probed at 135F and puree chicken fingers was probed at 133F, creamy cucumber salad (prepared with sour cream) was probed at 53F, minced cucumber salad at 52.9F, and puree cucumber salad at 50.5 F.

Food temperatures were not found to be safe and palatable as confirmed with dietary staff #400 and the FSM on April 27, 2016. [s. 73. (1) 6.]

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 food and fluids were served at a temperature that was both safe and palatable to the residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The record of resident #033 was reviewed including the progress notes and the care plan. The care plan included: "Responsive Behavior Risk Level Red as evidenced by increase inappropriate (sexual) behaviors, Dementia type unspecified". Interventions included: Try to redirect undesirable behavior (sexual). On one-to-one staff supervision to minimize episode responsive behavior. If available have male staff scheduled to do one-to-one."

Progress Notes indicated that on an identified date in August, 2015 the PSW assigned to provide one-to-one supervision of resident #033 was called away to assist with the care of another resident. The PSW assigned to the resident left resident #033 in bed. Resident #033 was moved to the hallway. While the PSW assigned to supervise resident #033 was assisting with the care of another resident, resident #033 was observed by staff inappropriately touching resident #032. There was no documentation to support that the staff attempted to redirect resident #033 prior to resident #033 inappropriately touching resident #032 nor was the strategy of 1:1 staffing implemented.

The home's records were reviewed including the Critical Incident report #2739-000051 and included: "The one to one was called away for a few moments to assist another PSW. The RPN was in the hallway providing medications and noted that the spouse of resident #033 took the resident out of the room and left the resident in the hallway. The RPN noted that the resident was in the hallway and before she could reach the resident, the resident inappropriately touched resident #032"

The Hamilton Police Service Referral Form included: The resident involved does have a one-to-one that has been directed to keep a distance from the resident but close enough to intervene. At the time, the one-to-one staff was called away and then the resident's spouse had removed the resident from the room and left the resident in the hallway.

The DOC was interviewed and confirmed that procedures and interventions were developed, however were not implemented on this date to assist residents and staff who were at risk of harm or who were harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: 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. A) The licensee failed to ensure that homes policy for head injury routine was complied with.

The home's policy "Head Injury Routine" policy number: RCS E-35, created: December 19, 2000, revised date: July 15, 2013 stated: Observation to be made for the resident with a recent head injury and documented in multidisciplinary progress notes: Is the resident responding to stimuli? Is there any weakness developing in the legs and arms? Is there any problems with increased headaches? Is there any nausea or vomiting? Is there any leakage of fluids from ears and nose? Is there any abnormal shaking of limbs? Are there any complaints of seeing double or squinting? Is there any change in balance? Are there any complaints of neck pain or stiffness? Is there any seizure activity?

A review was completed of resident #021's clinical record. The resident had falls on identified dates in January, June, and September, 2015, each one resulting in a head injury. The fall that occurred in September, 2015, resulted in the resident being transferred to hospital two days later. The resident declared palliative and passed away the same day. A review of the clinical record identified that these questions on the head injury routine policy were not completed during the head injury routine on resident #021 as confirmed by the Director of Care.

2. The licensee failed to ensure that home's policy for bed rails was complied with.
The home's policy "Bed Rails" policy number: RCS E-05, created: December 19, 2000, revised date: August 10, 2013 stated: The need for bed rail(s) will be reassessed with any change in the resident's status or at least quarterly to reduce the risk of entrapment.

A review was completed of the resident #005 and #008's Interdisciplinary Restraint/PASD (Personal Assistance Services Devices) Assessment and Consent forms. The Director of Care (DOC) stated that the expectation of the home was that the quarterly assessments where to be completed for residents with restraints/PASD's by their assigned documentation nurse. Two of two consents reviewed did not have any evidence of the quarterly assessments being completed as confirmed by the DOC. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policies for head injury routine and bed rails were complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 20, 2016, in the shared bathroom of an identified room, soiled continence products (brief) and soiled clothing were found in the bathroom sink. It was brought to the attention of nearby PSW#100 who confirmed that it should not be there and promptly cleaned it up. Staff failed to participate in the implementation of the infection control program. [s. 229. (4)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

A variety of lighting fixtures on all floors were measured, however not all areas were tested. Those that were tested are listed below. Only 2 different types of resident rooms were measured (double and four bed rooms). The licensee had hired a contractor to complete the upgrades to the lighting levels and identified in a letter to the home, that the entire facility was either retrofitted or new lighting installed depending on the existing conditions and lux requirements. All lighting tested, except for the washrooms on 2nd, 3rd and 4th floor measured at the lux level requirements.

Light fixtures were measured using a portable digital light meter, held 30 inches above and parallel to the level of the floor. Outdoor lighting conditions were overcast at the time of measurement and all efforts were made to close blinds and drapery to block out the natural light.

Corridor lights were equipped with double strip 4 foot fluorescent tubes with opaque lens covers, with the exception of the new two foot two bulb fluorescent tubes lights with opaque covered lens that have been added into various hallways since the previous inspection. All of the corridors now have the required consistent and continuous lux of 215.28, except in the center of two of four long corridors. The lux levels noted in the center of these two long corridors, measured between 146 to 161 lux.

All dining rooms have had lighting fixtures added; or new lighting installed, and now have the required consistent and continuous lux of 215.28. All dining rooms measured between 390 and 1020 lux.

All lounges have had lighting fixtures added or new lighting installed, and now have the required consistent and continuous lux of 215.28.

All resident's bedrooms, have had two bulb round ceiling mounted lights with opaque lenses with incandescent bulbs installed at the foot of each bed since the last inspection. The lighting level on the path of travel in the rooms tested, met the consistent and continuous requirement of 215.28 lux.

Resident's rooms on all floors with the newly installed lights at the foot of each bed, now have the required consistent and continuous lux of 376.73. A minimum of 376.73 lux is required for over-bed lighting, and a minimum level of 215.28 lux in all bedrooms for general light.

Washrooms on the 1st floor were equipped with a forty inch mounted fixtures with two florescent bulbs with an opaque lens cover that when measured, ranged in illumination levels between 166 and 211 lux above the sink and toilet. In the rooms tested, the sink and the toilet were not located under the light. These lighting fixtures were noted to only have one bulb in each light instead of two. An additional bulb, when installed in one fixture met the consistent and continuous lux of 215. 28.

Washrooms on the 2nd, 3rd and 4th floor were equipped with an eighteen inch two bulb

vanity light with opaque glass shade. In the washrooms tested the sink sat directly under the light and met the lux requirement. In all the washrooms tested the toilet sat on the opposite wall to the light, and when measured, ranged in illumination levels between 88 and 160 lux. A minimum of 215.28 lux is required in washrooms. [s. 18.]

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that alternatives to the use of a Personal Assistance Service Devise (PASD) had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

The record of resident #034 was reviewed including the Interdisciplinary Restraint/PASD Assessment and Consent dated November, 2014. The Least Restraint Alternatives Assessment Form was blank. There was no evidence found in the resident's record that alternatives to the use of the PASD were tried.

The DOC was interviewed and reported that the family requested the PASD. The DOC confirmed that alternatives to the use of a PASD had not been considered or tried to assist resident #034 with the routine activity of living. [s. 33. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that alternatives to the use of a Personal Assistance Services Device (PASD) had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

The home's policy and procedures Abuse and Neglect Policy #RCS P-10, Revised Date: July 2, 2015 was reviewed and it included: Where a staff member has reason to believe that a Resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the Home, and to the Director appointed under the Long-Term Care Homes Act, 2007(LTCHA) (the "Director of Long-Term Care Homes"). The policy also included: "Staff must adhere to the mandatory reporting obligations set out in the LTCHA, which include the above described reports" and "Any alleged, suspected, or witnessed incidents of abuse or neglect are to be reported to the Home as well as to the Director of Long-Term Care Homes".

The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on another identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the record of resident #33 that on an identified date in August, 2015 a staff member observed resident #033 inappropriately touching resident #044.

The home was requested to produce the home's records related to the sexual abuse incidents involving resident's #033 and #044; however, the home did not produce the requested information.

The DOC was interviewed and reported that the staff members who witnessed the incidents did not report the incidents to the home as per the home's policies and procedures. The DOC confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents was not complied with by staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, is available in every area accessible by residents.

During the initial tour of the home on April 19, 2016, it was noted that there was no call bell in the hairdressing salon as confirmed with the hairdresser and the Administrator on the same date.
The home was not equipped with a resident-staff communication and response system accessible in the hair salon. [s. 17. (1) (e)]

Issued on this 15th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2016_322156_0006
Log No. / Registre no:	010694-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 3, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	DUNDURN PLACE CARE CENTRE 39 MARY STREET, HAMILTON, ON, L8R-3L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Watson

To RYKKA CARE CENTRES LP, 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 :

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

Order / Ordre :

The licensee shall complete the following:
1. Re-assess all bed systems using the Health Canada Guidelines tilted "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".
2. Implement interventions to reduce or eliminate entrapment zones for those residents who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention in the residents' plan of care.
3. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
4. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
5. All health care workers shall receive education on the hazards of bed rail use.

Grounds / Motifs :

1. 1. The order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with r. 15 (1) (a) of the Regulation, in respect to the potential harm for resident #035 and #036, the scope of this being

a widespread issue in the home, severity as potential for actual harm and the licensee's history of non-compliance with a (VPC) in February 2015, during the Resident Quality Inspection for r. 15. (1) (a).

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

A) Resident #008 was observed to have a quarter rail in the "down" or engaged position on the right side of the bed and a quarter rail in the "up" position on the left hand side of the bed throughout the inspection. The resident reported that both bed rails were used; however, the plan of care for this resident indicated that only one bed rail was used as a positioning device.
Interview with registered staff #200 on April 22, 2016 reported that only the rail that was in the "down" position is assessed for all residents. A review of the home's "Interdisciplinary Restraint/PASD Assessment and Consent" completed by registered staff #200 dated March, 2016 had the "PASD bed rails" box checked off but the assessment was not completed.
Neither bed rail was assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #200 on April 22, 2016 and the Director of Care (DOC) on April 26, 2016.

B) Resident #005 was observed to have a quarter rail in the "down" or engaged position on the left side of the bed and a quarter rail in the "up" position on the right hand side of the bed throughout the inspection. The plan of care for this resident indicated that one bed rail was used as a positioning device.
A review of the home's "Interdisciplinary Restraint/PASD Assessment and Consent" for this resident completed had the "PASD bed rails" box checked off but the assessment was not completed.
Neither bed rail was assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with the Director of Care (DOC) on April 26, 2016.

C) On April 26, 2016, The DOC confirmed that approximately 80% of the beds in the home had quarter rails in the 'up' position as part of the bed systems. The rails were either "up" or "down/engaged". It was confirmed that residents with these rails in the "up" position had not been assessed and his or her bed systems evaluated in accordance with evidence-based practices, and if there

were none, in accordance with prevailing practices to minimize risk to the residents.

D) The record of resident #034 was reviewed and it was noted that on an identified date in May, 2015 the resident was transferred from one identified floor (A) to another floor (B). While on floor A, the resident used two bed rails and wedges. When the resident moved to floor B, they were placed in a new bed with bed rails and wedges as they had been using on floor A . A bed rail assessment dated in May, 2015 was not found in the resident's record. The resident fell several times and a bed rail assessment was completed eleven days later in May, 2015. The DOC was interviewed and they confirmed that a bed rail assessment completed in November, 2014 and May, 2015 were the only bed rail assessments available. The DOC confirmed that a bed rail assessment was not completed in May, 2015 when the resident initially moved into a new bed on floor B. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

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. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The home shall develop a protocol that identifies the home's general program requirements that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Grounds / Motifs :

1. The order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with r. 30 (2) of the Regulation, in respect to the home's general program requirements, the scope of this being isolated, severity at actual harm or risk to residents and the licensee's history of non-compliance with a (VPC) in February 2015, during the Resident Quality Inspection for r. 30 (2).

The licensee failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) On identified dates in January, June, and September, 2015, resident #021 had falls each one resulting injury. The fall that occurred in September, 2015, resulted in the resident being transferred to hospital two days later. The resident declared palliative and passed away the same day. A review of the clinical record identified that the three falls all occurred between the hours of 0215 hrs and 0700 hrs. Each of these falls occurred when the resident, who was visually impaired, was attempting to go to the bathroom. The plan of care for resident #021, identified that the resident required assistance for the physical process of toileting related to impaired vision and pain. The plan of care also stated, that

the resident was to be assisted to the washroom between 0100 to 0200 hrs and 0500 to 0600 hrs, as the resident may attempt to self toilet. A review of the flow sheets for the dates of the falls, identified that on the three nights that the falls occurred, the documentation for each of these nights only reflected that the resident was toileted one out of two times each shift or 50% (percent) of the toileting times. Personal Support Worker (PSW) #102 when interviewed identified that resident would often refuse. The PSW also confirmed that the refusals were not documented. The home did not ensure that the interventions in place for resident #021 through their falls prevention program were reassessed, and the resident's responses to interventions documented.

A review of the risk management incident reports for the January, June and September, 2015, were completed. The homes expectation of the registered staff when completing the incident reports, was to complete all sections. In each of the three falls, resident #021 sustained injury. One of the sections to be completed was pain. The registered staff where to ask the resident who is able to respond what their pain level is on a scale of one to ten. On review of the risk management incident reports for the three falls, it was noted that on the January, 2015 incident report, that the resident was asked if they had pain by the registered staff. The resident identified that their pain was nine out of ten. There was no further evidence in the clinical record that any further investigation was done to address the resident's complaints of pain. Staff #206 who completed the incident report confirmed they had not completed the pain section. The home did not ensure that assessments and the resident's responses to interventions were documented.

B) The records of residents #033 and #044 were reviewed including the progress notes and it was noted in the record of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044. No documentation related to the above abuse incident was found in the record of resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the progress notes of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044. No documentation related to the above abuse incident was found in the record of resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the

progress notes of resident #033 that on an identified date in August, 2015 a staff member observed resident #033 inappropriately touching resident #044. No documentation related to the above abuse indent was found in the record of resident #044.

The DOC was interviewed and confirmed that there were no progress notes documented in the record of resident #044 from identified date in July, 2015 and that there was no documentation in the resident's record related to the abuse incident of August, 2015.

The DOC confirmed that any actions taken with respect to resident #044 in relation to the three incidents above including assessments, reassessments, interventions and the resident's responses to interventions were not documented.

C) The record of resident #007 who had a wound on an identified area was reviewed
including the progress notes and "Pixalere" wound record. There was no documentation of the
wound being assessed between for a one month time period beginning in March, 2016.

The home's Wound Care Nurse was interviewed and confirmed that there was no documentation available of the wound assessments for resident #007 beginning in March 2, 2016. (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is requested to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with s. 19 (1) of the Act, in respect to protecting residents from abuse or neglect, the scope of this being a pattern in the home, severity of actual harm or risk to residents and the licensee's history of non-compliance with a (VPC) in February 2015, during the Resident Quality Inspection for s. 19 (1).

The licensee failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

The records of residents #032 and #033 were reviewed. It was noted that on an identified date in August, 2015 resident #033 inappropriately touched resident #032. Resident #032 called resident #033 a name.
The records of residents #031 and #033 were reviewed. It was noted that on an identified date in September, 2015 a staff member witnessed resident #033 inappropriately touching resident #031.
The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on an identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.
The records of residents #033 and #044 were reviewed and it was noted in the record of resident #033 that on another identified date in July, 2015 a staff member witnessed resident #033 inappropriately touching resident #044.

The records of residents #033 and #044 were reviewed and it was noted in the record of resident #33 that on an identified date in August, 2015 a staff member observed resident #033 inappropriately touching resident #044.

The home's records were reviewed including Critical Incident (CI) reports: #2739-000051-15; #2739-000058-15; #2739-000016-16; #2739-000017-16 and 2739-000018-16 and they included information as above.

The Director of Care (DOC) was interviewed and confirmed information as included in the residents' records and the home's records. The DOC confirmed that residents #0031, #032 and #044 had cognitive impairments and did not consent to the inappropriate touching by resident #033.

The licensee failed to protect residents #031, #032 and #044 from abuse by resident #044. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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
TORONTO, 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
TORONTO, 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 3rd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

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

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