Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 26, 2014	2014_323130_0003	H-000269-14	Resident Quality Inspection

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

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

WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

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

GILLIAN TRACEY (130), IRENE PASEL (510), KATE MACNAMARA (540), KELLY HAYES (583), ROBIN MACKIE (511)

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): March 10, 11, 13, 14, 17, 18, 19, 21 and 22, 2014.

Please note: This inspection was conducted simultaneously with the following complaint inspections: H-000239-13, H-000731-13, H-000430-13, H-000780-13, H-00057613 and H-000269-14.

The following IPs were not fully reviewed during this inspection and will be inspected by the Environmental Health Inspector at a future date: Accommodation Services: laundry and housekeeping, safe and s3ecure home and infection control.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Manager of Food Services, Manager of Environmental Services, Manager of Recreation Services, registered staff, personal support workers (PSW), dietary staff, housekeeping staff, laundry staff, recreation staff, restorative staff, residents and families.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records, relevant policies and procedures, toured the home and observed programs and care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

a) Doors leading to stairwells in the basement of the home were not equipped with a door access control system that was kept on at all times. The basement was utilized by numerous residents to attend recreation programs and physiotherapy services. On Monday, March 17, 2014, an identified resident was found on the stairwell side of the locked stairwell door on level two of the home. Staff confirmed the resident had been in attendance at a scheduled activity held in the basement. According to the plan of care and staff interviewed, the resident required assistance of staff for ambulation and mobilized in a wheelchair most of the time. Staff confirmed that the doors from the basement level leading to the stairwells were not equipped with a door access control system and that the resident was not constantly supervised. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) The home's Skin Care Policy, 03-01 indicated: When the minimum data assessment (MDS) was completed registered staff were to complete a pressure ulcer rating scale (PURS) and determine if further investigation and care planning was required. Residents with a PURS score of four or greater should have further assessments completed to help define risk associated with skin breakdown. The Braden Scale assessment was to be completed for these residents to provide further insight into the risk factors for skin breakdown. The quarterly MDS assessments completed for resident #156, on two identified dates in 2013, identified the resident had a PURS score of four. The RAI Coordinator confirmed that Braden Scale assessments were not completed for this resident, as per the home's policy.

b) The home's Skin Care Policy, 03-01, indicated that on hire and annually care staff would receive education in preventative skin care as well as wound care for registered staff. The DOC confirmed there was no curriculum available for education in preventative skin and wound care for staff and that registered staff did not receive education in preventative skin and wound care at this time.

c) The home's Skin Care Policy, 03-01, indicated monthly statistics related to skin care would be collected and analyzed by the Skin Care Coordinator or designate. The DOC confirmed statistics related to skin care were not being collected and analyzed at this time.

d) The home`s policy Drug Destruction and Disposal 5-4 indicated : Non-Monitored Medications, 1. Nurse was to identify on an ongoing basis (suggested weekly), any medication for disposal by: a) completing scheduled checks for expired goods. On a specific date in 2014, the medication storage room, and the first and second floor medications rooms were toured and all locations contained expired gravol suppositories. The DOC confirmed registered staff were not completing weekly medication room audits as required by policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that, a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, (iii) was assessed by a registered dietitian who was a member of the staff of the home and (iv) was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

a) Clinical records indicated resident #147 sustained a large skin tear on an identified date in 2013. A skin assessment was not completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument nor was the resident referred to the registered dietitian for this alteration in skin integrity. Clinical records revealed a head to toe assessment was completed on a specific date in 2013, which noted, in addition to a skin tear, two new stage two pressure ulcers to identified areas. These alterations in skin integrity were not reassessed at least weekly by a member of the registered nursing staff as the clinical records indicated one affected area was not reassessed until a later date in 2014. There was no further

documentation in the resident's clinical record for one affected area. Interview with the DOC confirmed the staff had not assessed the resident using a clinically appropriate assessment instrument, had not completed weekly skin assessments and had not completed a referral to the registered dietitian for this resident.

b) Progress notes reviewed for resident #002 indicated the presence of skin impairment to an identified area on an identified area in 2013. Documentation on a specific date in 2013, indicated the area had opened and was described as a "3.3 cm" wound to the affected area. There was no evidence of referral to registered dietitian until later in 2013. There was no evidence of consultation with a physician regarding medical management, until referral to a nurse practitioner (NP) sometime later in 2013. There was no further documentation of the wound until after the referral to wound care was made. The NP consult in 2013, described a large unstageable ulcer to the identified area. There was no documented skin and wound assessment using a clinically appropriate assessment instrument over a seven month period in 2013. The resident eventually required medical treatment for the affected area. This information was confirmed by staff.

c) Resident #002 was readmitted to the home on an identified date in 2013. A skin assessment completed at that time identified impaired skin integrity There were no further skin assessments completed for four month. Staff confirmed that there were no weekly skin assessments completed by a member of the registered nursing staff over the four month period in 2013.

d) Resident #156 returned to the home from hospital on an identified date in 2013. Registered staff confirmed the resident was at risk for skin breakdown and did not have a skin assessment completed upon their return from hospital. [s. 50. (2) (b)]

Additional Required Actions:

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

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #144 indicated two staff assistance was required for bed mobility; two staff would turn and reposition the resident when in bed minimally every two hours, encouraging the resident to participate with turning by grabbing onto the one side rail. The same plan also indicated, extensive assistance for bed mobility, resident participated in bed mobility by use of rail to guide upper body from side to side, one staff would physically guide their lower body from side to side and limited assistance of one staff to provide guided manoeuvering or non weight bearing support via aide. The plan of care directed staff to ensure the physical restraint was applied when up, but the same plan indicated, staff apply a personal assistance services device (PASD) to improve resident's performance. Staff interviewed confirmed the plan did not provide clear direction regarding assistance requirements for bed mobility and need for either a restraint or PASD.

b) The plan of care for resident #144 indicated they had identified physical limitations,

however, the same plan provided conflicting statements regarding these limitations. Staff interviewed confirmed the resident was non ambulatory and that the plan did not provide clear directions regarding mobility status. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

a) The MDS quarterly assessment completed on a specific date in 2014, for resident #198, indicated the resident was continent of bowels. The written plan of care indicated the resident was frequently incontinent. Staff interviewed confirmed the resident was routinely continent of bowels. Registered staff confirmed the plan of care was not based on the assessment of the resident's needs.

b) A "nursing quarterly summary" completed in 2014, indicated the resident assessment protocol (RAP) had been completed for resident #128. The assessment indicated, due to a recent health condition there was a change the level of assistance required from staff. The resident confirmed they required a increased assistance with certain tasks over past two weeks. The plan of care indicated the resident was independent with the identified tasks. Registered staff confirmed the resident's current plan of care was not based on the recently completed RAP. [s. 6. (2)]

3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) The plan of care for resident #144, indicated the resident required a specific intervention put in place to minimize injuries from falls; staff to apply in morning and remove at bedtime and ensure foot rests were on wheelchair once transfer was complete and they were seated. The resident was observed on a specific date in 2014, foot rests were not on the wheelchair and staff confirmed the identified intervention was not put in place.

b) Clinical records for resident #147, indicated, on the Braden risk assessment completed in 2013, the resident was at moderate risk for alteration in skin integrity. In 2014, clinical records revealed the resident had an area of impaired skin integrity. A treatment was prescribed to be applied at specific times for seven days to the affected area. A review of the resident's treatment record confirmed the resident did not receive the treatment twice a day on at least six of the seven days. Interview with the Director of care confirmed the resident did not receive the treatment as set out in the

plan of care. [s. 6. (7)]

4. The licensee did not ensure that the provision of the care set out in the plan and the effectiveness of the plan of care were documented.

a) According to the plan of care resident #006, received two specific treatments on four occasions during a specific month in 2014. Staff interviewed confirmed the effectiveness of the treatment was not documented in the plan of care.

b) Resident #007, received a medication on an identified date in 2014. Staff interviewed confirmed the effectiveness of the medication was not documented.

c) Resident #148, received an identified medication on at least four occasions during a specific month in 2014. Staff confirmed the effectiveness of the medication was not documented. [s. 6. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, that the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of the care set out in the plan and the effectiveness of the plan of care is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

a) A family member for resident #173, provided a written complaint to the home on an identified date in 2013. Interview with the Administrator confirmed the home did not forward the written complaint to the Director. [s. 22. (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 written complaints received concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director, 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:
8. Continence, including bladder and bowel elimination. 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).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure there was a plan of care based on, at a minimum, interdisciplinary assessment of continence, including bladder and bowel elimination, the resident's health conditions including risk of falls and other special needs and skin condition, including altered skin integrity and foot conditions.

a) According to assessments completed, resident #230 had a decline in continence over a three month period in 2013. Staff confirmed there was no written plan put in place to manage incontinence. [s. 26. (3) 8.]

2. The licensee did not ensure that there was a plan of care based on, at a minimum, interdisciplinary assessment of the resident's health conditions, including risk of falls and other special needs.

a) In 2014, resident #156 was assessed for falls risk and identified to be at high risk, the RAI Coordinator confirmed there was no written plan in place to manage fall risk.

b) According to the plan of care, resident #008 had sustained at least seven falls over a 10 month period in 2013. The DOC confirmed there was no written plan in place to manage the fall risk. [s. 26. (3) 10.]

3. The licensee did not ensure that there was a plan of care based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity and foot conditions.

a) Progress notes recorded in 2013, for resident #002 revealed a wound to an identified area. A consultation report completed by the dietitian, indicated the wound was large and unstageable. A written plan of care with the focus of impaired skin integrity was not created until sometime later in 2013. This information was verified by the RAI Coordinator.

b) On an identified date in 2014, resident #156 had a braden risk assessment completed, which identified the resident was "at risk" for skin breakdown. The quarterly MDS assessments completed over two quarters, indicated the resident's PURS score was four, which also indicated a risk for skin breakdown. The RAI Coordinator confirmed there was no written plan put in place to manage risk of skin breakdown. [s. 26. (3) 15.]

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 there is a plan of care based on, at a minimum, interdisciplinary assessment of continence, including bladder and bowel elimination, the resident's health conditions including risk of falls and other special needs and skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #7: 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 did not ensure that when the resident had fallen, a post fall was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) Resident #156 sustained a fall with injury on a identified date in 2013. Registered staff confirmed the resident did not have a post fall assessment completed, using a clinically appropriate assessment instrument. [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, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: 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 did not ensure that food and fluids during dining service were served at a temperature that was both safe and palatable to the residents.

a) During lunch observation on March 10, 2014, three residents' meals were served from the steam table, plated and covered for room delivery. Trays were delivered 15 minutes after plating and temperatures were not checked.

b) During lunch service on March 14, 2014, on the first floor, five meals were plated on trays and covered for room delivery. Delivery of trays began 15 minutes after plating. A temperature check was requested, two staff members were unable to locate thermometer. Inspector's thermometer was used to measure the hot food items on the tray. The sausage was probed at 38.9 degrees Celsius and the soup was probed at 53.1 degrees Celsius. The staff were unable to identify the minimum temperature requirements for hot items per Policy DIET-07-01-03 version June 2013. On the second floor dining room, three trays were waiting to be delivered. Inspector requested temperature check of one tray once delivery started. Soup was the only hot menu item and was probed at 48 degrees Celsius.

c) It was confirmed by staff that hot foods being served were not palatable for residents receiving trays in their rooms as the temperatures were less than 60 degrees Celsius. It was also confirmed with staff and by review of food temperature record sheets that temperatures were checked and recorded once food arrived to dining rooms from the kitchen. [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 during dining service are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act,the long-term care home ensured that, (b) a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents.

a) On observation at 1100 hours on March 21, 2014, two resident beds were observed to have pillows without pillow cases. The first floor linen cart was observed at 1100 hours and only four towels were available, one blanket and three sheets. There were no pillow cases or face cloths on the linen cart nor in the supply room, available to front line staff on the first floor. A record review of the Family and Resident Council minutes was completed and on November 20, 2013, there were documented concerns related to lack of towels, peri-.cloths and facecloths identified. This complaint was also documented on the January 15 and February 19, 2014, Residents' Council minutes. Interview with a PSW confirmed they were short pillow cases on the observed date in the morning and have had insufficient supply of face cloths, peri-cloths, towels and pillow cases available for resident care in the previous three months. Interview with the Environmental Manager confirmed linen shortage had been identified as an issue in the previous month and specifically, the linen was short in the morning of the observed date, due to a washing machine that was broken and not in service. [s. 89. (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 a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee did not ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

a) The Administrator and the Director of Care reported the Falls and Restraints Committees were required by policy to meet monthly, to analyze falls and restraint use; however, they verified the Committee had not held a meeting since October 2013. [s. 113. (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 an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee did not ensure that training was provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

a) The education records reviewed indicated a Least Restraint education session was held on one occasion on November 1, 2013. The DOC confirmed that the session was not repeated and therefore the education was not made available to applicable staff. [s. 221. (1) 5.]

2. The licensee did not ensure that training was provided for all staff who apply PASDs or who monitor residents with PASDs including: application of these PASDs, use of these PASDs and potential dangers of these PASDs.

a) The education records indicated a Least Restraint education session, which included PASD vs Restraints, was held on one occasion on November 1, 2013. The DOC confirmed that the session was not repeated and therefore the education was not made available to applicable staff. [s. 221. (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 training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices, use of these physical devices, and ensure that training is provided for all staff who apply PASDs or who monitor residents with PASDs including: application of these PASDs, use of these PASDs and potential dangers of these PASDs, to be implemented voluntarily.

WN #12: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure there was a staff immunization program in place in accordance with evidence-based practices or in accordance with prevailing practices.

The "Best Practices for Infection Prevention and Control Programs in Ontario in All Health Care Settings, 3rd edition" by the Provincial Infectious Diseases Advisory Committee (PIDAC) (rev. 2012) indicated:
a) that the communicable disease status at the time of employment of all health care providers should be evaluated and should include vaccination status and serologic screening for select vaccine preventable diseases
b) health care providers must be offered appropriate vaccinations for communicable diseases
c) staff vaccination rates should be used as a patient safety indicator
d) health care provider vaccinations should include tetanus, diptheria, influenza, hepatitis B, varicella (if not immune), measles/mumps/rubella, acellular pertussis and other vaccinations as indicated.

a) A medical record audit of three staff files revealed that staff were assessed for tuberculosis status and offered an annual influenza vaccine, consistent with organizational policy. The Administrator confirmed that no other immunization history was required and no other immunization program was offered to staff. [s. 229. (10) 5.]

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 there is a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Physical Restraints Policy: RESI-10-01-01, Version November 2012, was complied with.

The home's policy indicated: 1. At a minimum, the resident's response to the restraint and the need for continued use of the resident must be evaluated each shift and documented either on the Resident Record, or where e-documentation is in place. 2. Restraint re-assessment shall be completed at a minimum quarterly.

a) Resident #144 was observed with a physical device applied, which staff identified as a physical restraint. Staff interviewed confirmed a restraint assessment had not been completed since early 2013. The Director of Care confirmed the registered staff were not reevaluating the continued need for the restraint each shift as required by their policy.

b) Resident #178 and #202 were both observed to have physical devices applied. Clinical records indicated the devices were being applied as physical restraints. Upon further review of the documentation, the restraints were not being assessed quarterly as per the home's policy. Both residents had only one physical restraint assessment completed in 2013. Interview with the Director of Care confirmed the quarterly restraint assessments had not been completed for resident #178 and #302. [s. 29. (1) (b)]

WN #14: 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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

a) The initial plan of care developed for resident #008 in 2013, indicated the resident was usually continent of bowel and bladder with routine toileting. The plan of care reviewed and revised later in 2013, indicated the resident was incontinent and using incontinence products. The DOC confirmed there were no continence assessments completed during the time period this time period.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

a) On observation cognitively impaired resident #166 was noted to be ambulating about the unit exhibiting responsive behaviours. The plan of care indicated the resident had been identified with responsive behaviours and referred to Behaviour Support Ontario (BSO) on an identified date in 2014. An Abby pain scale, completed in 2014, confirmed they were experiencing moderate pain and that pain was a trigger for the responsive behavior. Pain medication was ordered to be given twice a day on a specific date in 2014, along with pain medication to be given every four hours on an as needed basis. This physician's order was then increased to three times a day along with pain medication to be given every four hours on an as needed basis. The resident was not assessed for pain, using a clinically appropriate assessment instrument designed for this purpose, when the resident's pain had not been relieved, resulting in an increase in pain medication. This information was verified by the DOC. [s. 52. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee did not ensure that the drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

a) On March 21, 2014, the medication storage room was noted to have the following stock: 25 bottles of cascara, 24 bottles of almagel, 22 bottles of milk of magnesia and 40 bottles of isopropyl alcohol. The The DOC confirmed this amount of stock exceeded their three month usage. [s. 124.]

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

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #002	2013_201167_0022	130
O.Reg 79/10 s. 135. (2)	CO #003	2013_201167_0022	130
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_191107_0003	130
O.Reg 79/10 s. 8. (1)	CO #001	2013_201167_0022	130

Issued on this 12th day of May, 2014

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

Gillian Tracey

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), IRENE PASEL (510), KATE MACNAMARA (540), KELLY HAYES (583), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_323130_0003
Log No. / Registre no:	H-000269-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2014
Licensee / Titulaire de permis :	1508669 ONTARIO LIMITED c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1
LTC Home / Foyer de SLD :	WEST PARK HEALTH CENTRE 103 Pelham Road, St Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARJORIE MOSSMAN

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

To 1508669 ONTARIO LIMITED, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home is a safe and secure environment for all residents attending programs or receiving physiotherapy services in the basement until the doors leading to stairwells in the basement are equipped with a door access control system that is kept on at all times. The plan shall be submitted to Gillian.Tracey@ontario.ca by April 8, 2014.

Grounds / Motifs :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

a) Previously issued CO on May 31, 2011.

b) Doors leading to stairwells in the basement of the home were not equipped with a door access control system that was kept on at all times. The basement was utilized by numerous residents to attend recreation programs and physiotherapy services. On Monday, March 17, 2014, resident #235 was found on the stairwell side of the locked stairwell door on level two of the home. Staff advised the resident had been in attendance at a scheduled activity held in the basement. Resident #235 resided on the first floor, the clinical record and staff interviewed verified the resident required supervision with ambulation and spent most of the time in their wheelchair. Staff confirmed that the doors from the basement level leading to the stairwells were not equipped with a door access control system and that the resident #235 was not constantly supervised while in the activity.

(510)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 22, 2014

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that any policy, procedure or system that the long term care home has put in place is complied with, specifically with regards to the following:

a) Skin and wound care program regarding completion of assessments using appropriate assessments tools.

b) Education for registered staff regarding Policy #03-01 related to preventative skin and wound care and the monthly collection of skin care statistics and analysis.

The plan shall be submitted to Gillian.Tracey@ontario.ca by April 8, 2014.

Grounds / Motifs :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) Previously issued as on December 20, 2012, VPC and August 26, 2013, CO.

b) The home's Skin Care Policy, 03-01 indicated: When the minimum data assessment (MDS) was completed registered staff were to complete review the pressure ulcer rating scale (PURS) and determine if further investigation and care planning was required. Residents with a PURS of four or greater should have further assessments completed to help define risk associated with skin breakdown. The Braden Scale assessment was to be completed for these residents to provide further insight into the risk factors for skin breakdown. The quarterly MDS assessments completed for resident #156 on two identified dates in 2013, identified the resident had a purse score of four. The RAI Coordinator confirmed that Braden Scale assessments were not completed as per the home's policy.

c) Policy #03-01, indicated that "on hire and annually care staff will receive education in preventative skin care as well as wound care for Registered Staff". The DOC confirmed there was no curriculum available for education in preventative skin or wound care for registered staff and that registered staff do not receive education in preventative skin and wound care at this time

d) Policy #03-01, also indicated monthly statistics related to skin care would be collected and analyzed by the skin care coordinator or designate. The DOC confirmed statistics related to skin care were not being collected and analyzed.

e) The home`s policy Drug Destruction and Disposal 5-4 indicated : Non-Monitored Medications, 1. Nurse was to identify on an ongoing basis (suggested weekly), any medication for disposal by: a) completing scheduled checks for expired goods. On March 21, 2014, the medication storage room and first and second floor medications rooms were toured and all areas contained expired gravol suppositories. The DOC confirmed registered staff were not completing weekly medication room audits as required by policy. (130)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff (ii) upon any return from hospital, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and (iv) is reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee did not ensure that, a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, (iii) was assessed by a registered dietitian who was a member of the staff of the home and (iv) was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

a) Clinical records indicated resident #147 sustained impaired skin integrity on an identified date in 2013. Clinical records reviewed did not confirm a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed nor was the resident referred to the registered dietitian for this alteration in skin integrity. Clinical records revealed a head to toe assessment was completed around the same time period, which noted, two additional areas of skin impairment, in addition to the one already identified. These alterations in skin integrity were not reassessed at least weekly by a member of the registered nursing staff. There was no further documentation in the resident's clinical record for two of the affected areas. Interview with the DOC confirmed the home had not completed weekly skin assessments and had not completed a referral to the registered dietitian for resident.

b) Progress notes reviewed for resident #002 indicated the presence of skin

impairment to a specific area in 2013. Documentation indicated the area had worsened and required treatment. There was no evidence of referral to registered dietitian until later in 2013. There was no evidence of consultation with a physician regarding medical management, until referral to a nurse practitioner (NP), which occurred sometime later in 2013. There was no further documentation of the wound until this time period. The NP consult described the affected area as unstageable. There was no documented skin and wound assessment using a clinically appropriate assessment instrument over a seven month period in 2013.

c) Resident #002 had a skin assessment completed in early 2013, following an absence from the home, which revealed a staged ulcer. Another skin assessment was not completed until the end of 2013. Staff confirmed that there were no weekly skin assessments completed by a member of the registered nursing staff over a five month period in 2013.

d) Resident #156 returned to the home following an absence in 2013. Registered staff confirmed the resident was at risk for skin breakdown and did not have a skin assessment completed upon their return. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

Ministère 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

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

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

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

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

Issued on this 26th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Gillian Tracey

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

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