Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2018	2018_718604_0006	009728-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Maple Health Centre
10424 Keele Street Maple ON L6A 2L1

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

SHIHANA RUMZI (604), JOVAIRIA AWAN (648), ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, and August 16, 2018.

The following Critical Incident System (CIS) report intakes related to alleged abuse in the home were completed during this inspection:
Related to medication administration:
Log #006394-18

The following intakes related to falls:
Log #029130-17

Intake #003526-18, related to the follow-up Order Amended (1) served on June 28, 2018, under s. 245 related to resident charges was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Supervisor of Care (SC), Accreditation/Compliance Advisor (ACA), Administrative Assistant (AA), Environmental Services Representative/Housekeeping, Registered Dietitian (RD), Food Services Supervisor (FSS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Resident Health Care Assistant (RHCA), Recreation Aide (RA), Housekeeping, Behaviour Support Resource Nurse (BSR), Dietary Aide (DA), Physiotherapy (PT), Residents, Substitute Decision Makers (SDMs), Presidents of the Residents' and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

Inspectors Adelfa Robles #723 and Miko Hawken #724 where shadowing the RQI process.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **1 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. 245.	CO #001	2018_523461_0002	604

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home.

Resident #008 triggered through stage one of the Resident Quality Inspection (RQI) for an alteration in skin integrity through the census record review.

A review of resident #008's Point Click Care (PCC) assessments indicated on an identified date an alteration in skin integrity was identified. The Inspector reviewed the assessment and did not find evidence to show an identified assessment by the dietitian was carried out. Further review of the assessments showed that the registered dietitian carried out an assessment at a later time after the alteration in skin integrity was discovered.

An interview was carried out with RPN #115 who indicated that it was the home's expectation that when a resident was identified with an alteration in skin, an initial skin assessment is to be carried out on PCC and at the time the skin issue was found a dietary referral is to be sent on PCC by the nursing staff in order for the registered dietitian to assess the resident. The Inspector and the RPN reviewed resident #008's assessments for an identified dates and a dietary referral was not completed until a later

time after the alteration in skin integrity was identified. The RPN acknowledge that it was not acceptable that a dietary referral was sent later and a registered dietitian assessment was not carried out at the time the alteration in skin was identified.

An interview was carried out with the Acting DOC #105 who indicated that when a skin alteration is identified a skin assessment is to be completed and the nursing staff is to send a dietary referral. The Acting DOC and the Inspector reviewed resident #008's referrals and a dietary referral to the registered dietitian was no found until a later date. The Acting DOC acknowledged that the registered dietitian of the home did not assess resident #008's status related to the resident's skin integrity until a later date.

2. Resident #008 triggered through stage one of the RQI for an alteration in skin integrity through census record review. Areas of noncompliance was identified for resident #008 and the sample size was expanded.

An identified assessment was carried out for resident #046 which indicated that on an identified date an identified area of alteration in skin integrity was found.
A review of resident #046's assessment history for the alteration in skin integrity was carried out for an identified period and Inspector #604 was unable to find a registered dietitian assessment for the alteration in skin integrity.

An interview was carried out with the Supervisor of Care (SC) #126 who is also the home's Skin and Wound Lead (SWL). The SC stated that it was the home's expectation when a resident is found to have an alteration in skin integrity the registered nurse is to inform Physiotherapy (PT), and send a dietary referral on PCC, and a weekly skin assessment is to be carried out. The SC indicated resident #046 had an alteration in skin integrity which since had resolved. The SC and Inspector #604 reviewed the assessment table on PCC for an identified period when the resident was identified has having alteration in skin integrity. The SC acknowledged that a referral to the registered dietitian was not sent when resident #046 was found to have an alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that when an area of altered skin integrity is identified a skin and wound assessment is to be completed and the nursing staff is to send referral to the dietary related when the site is identified to have the registered dietitian assess nutritional needs. The Acting DOC and the Inspector reviewed resident #046's referrals and a dietary referral was not found. The Acting DOC acknowledged that as the dietary referral was no found a registered dietitian did not carry out an assessment.

3. The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed and was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 triggered through stage one of the RQI for alteration in skin integrity through the census record review.

A review of resident #008's assessment on an identified date, indicated an identified alteration in skin integrity with no description of the alteration in skin integrity. Further review of assessments for alteration in skin integrity was carried out for an identified time period and Inspector #604 was unable to find a completed skin and wound assessment for resident #008's identified to have an alteration in skin integrity.
A review of resident #008's PCC progress notes were reviewed for an identified period related to the alteration in skin integrity and the inspector was unable to find any assessments.

On an identified date Inspector #604 carried out an observation with Registered Practical Nurse (RPN) #115, of resident #008's alteration in skin integrity and confirmed the alteration in skin integrity persisted.

An interview was carried out with RPN #115 who indicated that it was the home's expectation that when a resident was identified with an alteration in skin an initial assessment is to be carried out on PCC with a description of the alteration in skin, type of treatment, and interventions. The RPN also stated that a weekly skin and wound assessment is to be carried out until the skin has healed. The RPN stated resident #008 currently has an alteration in skin and a skin and wound assessment is to be carried out weekly. The RPN and Inspector #604 reviewed resident #008's assessments for an identified period of time and PCC progress notes. The RPN acknowledged that after reviewing the assessments and the PCC progress notes that there were assessments opened but not completed for the alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that it was the home's expectation that a weekly skin and wound assessment be carried out on PCC when a resident is identified to have skin breakdown. The Acting DOC and the Inspector reviewed resident #008's skin and wound assessments for the dates indicated above. The Acting DOC acknowledged that after reviewing the skin assessments and the PCC

progress notes that there were no weekly skin assessments completed for resident #008's alteration in skin integrity.

4. Resident #008 triggered through stage one of the RQI for an alteration in skin integrity through the census record review. Areas of noncompliance was identified for resident #008 and the sample size was expanded.

A "Skin and Wound" assessment was carried out for resident #046 indicating that on an identified date, an alteration in skin integrity was identified.

A review of resident #046's "Skin and Wound" assessment was carried out for an identified period and the Inspector was unable to find a completed skin assessments for the alteration in skin integrity.

An interview was carried with SC #126 who is also the home's new Skin and Wound Lead (SWL). The SC stated that it was the home's expectation when a resident is found to have an area of altered skin integrity the registered nurse is to carry out a weekly skin assessment thereafter until the area has healed. The SC indicated resident #046 had an alteration in skin integrity but has recently resolved. The SC and Inspector reviewed the skin and wound assessments on PCC from for an identified period when the resident was identified has having alteration in skin integrity and the SC acknowledged that a weekly skin and wound assessment was not completed for resident #046's alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that when an area of altered skin integrity is identified a skin and wound assessment is to be completed weekly by the nursing staff. The Acting DOC and the Inspector reviewed resident #046's identified assessments from an identified period as indicated above and the Acting DOC acknowledged that an identified assessment was not completed for resident #046 on a weekly basis.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

On an identified date and time Inspector #604 carried out a meal service observation on an identified home area. Three residents had been observed throughout the meal service. At an identified time the Resident Health Care Assistant (RHCA) #112 served the soup in a bowl to resident #024. The inspector noted that the resident did not have their identified adaptive devices on the table throughout the meal service.

A review of resident #024's written plan of care for an identified dated, indicated under the "Eating", focus that staff are to provide the resident with identified adaptive devices on the table.

On another identified date and time Inspector #604 carried out a meal observation on an identified home area and three residents had been observed throughout the meal service. At an identified time the Resident Health Care Assistant (RHCA) #112 served the soup in a bowl to resident #024 and the Inspector noted that the resident did not have their identified adaptive devices throughout the meal service.

Interviews were carried with RHCA #112, Food Services Worker (FSW) #114, and Registered Practical Nurse (RPN) #115, where the Inspector informed the staff of their observations and also reviewed resident #024's written plan of care. The RHC, FSW, and RPN acknowledged that resident #024 was not provided the care set out in the written plan of care as specified in the plan.

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 care set out in the plan of care had been provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 :

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

According to O.Reg 79/10 s.114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A review of the home's policy number five "Medication Management Obtaining and Keeping Drugs", with a review period of 2016, under the "Narcotics Count and Audits Count", directed staff in bullet number one that two registered (RN/RPN) will physically count and sign for narcotics and controlled/monitored substances together at the same time to serve as each other's witness. Bullet number two stated the count is to be done at the beginning and end of each shift. Performing a shift count ahead of time (prior to the end of shift) is not acceptable.

On an identified date and time Inspector #604 carried out a narcotic storage and audit observation an identified home area with Registered Nurse (RN) #104. During the narcotic audit the inspector noted that the "Narcotic and Controlled Drug Administration Record" sheets for six residents were signed off indicating an identified time.

An interview was carried out with RN #104, who stated that it was the home's policy to carry out the narcotic counts at the end of the shift with the oncoming nurse. The RN reviewed the above "Narcotic and Controlled Drug Administration Record" sheets and acknowledged that they had carried out the end of shift narcotic count on their own prior to an identified time, and had signed all the "Narcotic and Controlled Drug Administration Record" sheets for a future time, which was not the home's process.

The inspector expanded the sample.

On an identified date and time the Inspector carried out a narcotic audit observation on an identified location of the home with RN #125. The inspector noted that the "Narcotic and Controlled Drug Administration Record" sheets for 15 residents where signed off indicating a future time.

An interview was carried out with RN #125 who indicated to the inspector that it was the home's policy to carry out the narcotic counts at the end of the shift with two registered staff. The RN stated that they carried out the narcotic count on their own prior to going into the evening meeting. The RN stated they could not recall the time the narcotics where counted.

An interview was carried out with the home's Acting DOC who stated that the home expected and has educated all registered staff that narcotic counts are to be carried out by two registered staff at the end of the shift. The Acting DOC was provided the "Narcotic and Controlled Drug Administration Record" sheets for the identified home areas and was reviewed. The Acting DOC acknowledged that the nurse had carried out the narcotic count on their own and the home's policy was not followed.

2. According to O. Reg. 79/10, s. 136 (1) a, b, and d (i), Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, all expired drugs, all drugs with illegible labels, a resident's drugs where the prescriber attending the resident orders that the use of the drug be discontinued.

A review of the home's policy #15 "Medication Management Drug Destruction and Disposal", with the review period as 2016, indicated under the procedures in “Drug Destruction”, directed staff to ensure that
1) Expired medications, medications with illegible labels, medications that are not labelled properly, and medications that are no longer required will be destroyed and disposed of safely and securely.

2) Each nursing floor will have a clearly marked storage area for discontinued or outdated non-narcotic medications and non-controlled substances that is separate from drugs that are available for administration.

3) Drugs will be destroyed using methods to change their nature and render their use impossible or improbable, e.g. adding liquid to oral medications to create a slurry, opening injectable and wasting them into the medical container, or cutting/ folding over patches and placing in the medical container.

During stage one and two of the Resident Quality Inspection (RQI), Inspector #653 had conducted a number of observations of resident #021 in an identified area of the home. On two identified date and times the inspector observed the multiple medications to be stored in an identified area of the home.

A review of resident #021's “Physician's Digiorder” forms revealed identified medication orders.

Interviews were carried out with RPN #146 and with the Acting DOC. The RPN and Acting DOC of the above observations, and acknowledged that the home's policy on drug destruction and disposal had not been complied with as resident #021's prescribed medication was discontinued by the physician and the expired medication was inappropriately stored, had not been disposed of safely and securely by staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee had failed to ensure that all doors leading to non-residential areas restricted unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

The initial tour of the home was carried out on an identified date and at an identified time Inspector #604 observed an identified door was found to be propped open with brown paper towel, and the door was equipped with a pin pad. The home's Team Leader for Housekeeping (TLH) #102 arrived and the inspector went in to the room with the TLH. The room consisted of a tub, celing lift, Arjo Hunter All Purpose Disinfectant, and an Enthermatic DC 350 Towel warmer which was on, and the glass door was warm to touch. The towel warmer did not display the temperature.

An interview was carried out with the home's TLH #102 who confirmed the identified door was unlocked and stated the door is to be locked at all times as it was not a resident designated area. The TLH acknowledged that the room consisted of Arjo Hunter All Purpose Disinfectant and an Enthermatic DC 350 Towel warmer which was on and the glass door was warm to touch with no temperature displayed. The TLH stated that the towel warmer is to have a regulated temperature in order to control temperatures but towel warmer temperature was not displayed.

An interview was carried out on with the home's Assistant Supervisor of Care (ASC) # 103 who was informed of the above observations. The ASC stated that identified doors in the home are be locked at all times as it is not a resident area and if resident is in the room it is with the supervision of a staff. The ASC and inspector went up to the identified room and observed the Enthermatic DC 350 Towel warmer. The Inspector observed that when the towel warmer was touched it was hot to touch and this was acknowledged by the home's ASC. The ASC stated the temperature is to be displayed. The ASC acknowledged that the door being left open posed a risk to residents as the temperature of the towel warmer was not regulated and posed a risk to residents.

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 doors leading to non-residential areas restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee had failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

The initial tour of the home was carried out on an identified date and at an identified time Inspector #604 observed an identified door to be propped opened with the yellow "Floor Caution" sign. The Inspector noted a staff down the hall who arrived to the door.

An interview was carried out with Housekeeper #101 who stated that the key to identified door was broken and it was to be fixed today and acknowledged the door was open and the door is to be kept locked at all times as there are chemicals in the room and the resident might ingest or take it. During the interview the TLH #102 arrived and entered the room with the inspector. The following chemicals were found in the room:
-PerDiem 61 Disinfectant Cleaner
-Oxivir Five 16 Concentrate 57: confirmed to have 25% Oxygen Peroxide
-Diversey Sure Trac Ultra: Floor Cleaner
-Clorox Urine Remover
-Spitfire RTU Power Cleaner
-Diversey Emeral Plus Alkaline Cream Cleanser
-Utrex Daily Washroom Cleaner
-Citrus Blast Odour Counteractant
-Bio-Scavenger Uric Acid Eliminator
-Refresh Clear Foam
-DebStoko Deb Instant Foam Alcohol Hand Sanitizer

An interview was carried out with the TLH#102 who acknowledged the identified room door was unlocked and the door was to be locked at all time as chemicals where accessible to residents when the door was propped open.

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 hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee had failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include a description o the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. reported to the Director the description of the incident.

The home had submitted Critical Incident System (CIS) report on an identified date, to the MOHLTC Director, indicating 22 resident's had not received their medications/treatments on an identified shift.

The CIS report stated that on an identified home area 22 residents were not given their medication and or have treatment/assessment completed as ordered on an identified date and time. The inspector reviewed the home's amended CIS report and noted that

the staff involved in the incident was not included in the CIS report.

As a part of the home's investigation they had carried out three separate interviews with RN #148 who was involved in the above CIS incident. A portion of the investigation files included Personal Health Information (PHI). In this file it indicated that five residents empty medication strips were found in RN #148's private home. The inspector was unable to understand as to how the medication strips ended up in the RN's private home.

An interview was carried out with the home's Acting DOC #105. The Inspector asked the Acting DOC related to how the home came to know of the medication incident above. The Acting DOC stated that a medication incident form was provided to them related to the incident as indicated above for which the home carried out an investigation for. The DOC acknowledged that when the CIS report was completed and amended the home did not include the following information in the CIS report to the MOHLTC Director:
-Staff interviews related to their observation of RN #148
-Family member concern related to RN #148
-Concerns found in the review of the medication sheets for the shift worked by RN #148
-Home's video surveillance footage findings
-An interview statement by RN #148
-Police involvement

The amended CIS report for an identified date was reviewed by the Inspector and the Acting DOC. Inspector #648 read out the legislation r.104 requirements to the Acting DOC who acknowledged that the CIS report did not consist of the information provided to the inspector during their interview related to the home's investigation and the Acting DOC indicated the CIS report would be amended to consist of the missing information.

2. The licensee had failed to ensure that the report to the Director included the names of any staff members involved in the incident.

Through the mandatory medication administration inspection protocol requirements the inspector reviewed the home' medication incidents for an identified period of time. The home had submitted CIS report on an identified date, to the MOHLTC Director, indicating 22 residents had not received their medications/treatments on an identified shift.

The CIS report stated that on an identified home area 22 residents were not given their medication and or have treatment/assessment completed as ordered on an identified

date and time. The inspector reviewed the home's amended CIS report and noted that the staff involved in the incident was not included in the CIS report.

An interview was carried out with the home's Acting DOC #105. The initial CIS report submitted on an identified date and the amended CIS reports was reviewed by the Inspector and the Acting DOC related to RN #148 not being identified in the initial CIS report or the amended CIS report. The Acting DOC acknowledged that the CIS report did not consist of RN #148's name.

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;
-they report to the Director the description of the incident,
-the report to the Director included the names of any staff members involved in the incident,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee had failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On an identified date and time, Inspector #116 entered an identified home area and observed a medication cart in the hallway unsupervised. A identified prescribed medication for resident #013 was stored on top of the medication cart.

RPN #104, who was assigned to the cart was noted to be in a resident's room administering medications. The staff member returned to the cart at an identified time, and indicated that they did not return the identified medication to the medication cart after they had administered the medication to resident #013. RPN #104 acknowledged that all drugs are to be stored in an area or a medication cart that is secure and locked.

An interview held with the DOC confirmed that RPN #104 failed to ensure that prescribed medications where stored in an area or a medication cart that is secure and locked.

2. During stage one of the RQI, Inspector #653 conducted an observation of resident #021 in an identified area of the home on an identified time and date. The Inspector observed medications to be stored in an identified area of the home unlocked.

The Inspector had observed resident #021’s identified medication to be stored in an identified location of the home unlocked.

The same observations as above was made by inspectors #653 and #723, on another separate date and time.

In interview conducted with RPN #146 and the Acting DOC who acknowledged that resident #021's above mentioned medications were not stored in an area or a medication cart that was secure and locked.

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 drugs were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee had failed to ensure that no drugs were used by a resident in the home, unless the drug had been prescribed for the resident.

During stage one of the RQI, Inspector #653 had conducted an observation of resident #012 in an identified date and time. The inspector had observed medications to be stored inappropriate in an identified location of the home.

Inspectors #653 and #723, carried out another observations on another date and time for resident #012 in an identified area of the home and found the same medications to be stored in the same location of the home. The medications did not consist of a prescription label indicating the identified medication had been prescribed to the resident for use.

An interview held with resident #021 who indicated that they had been using the identified medication on a daily basis.

A review of resident #021's most recent three month medication review signed by the physician, the subsequent orders, the resident's EMAR and Electronic Treatment Administration Record (ETAR), and an interview held with RPN #146, did not show evidence of a physician's order for the use of the identified medication.

An interview was carried out with the Acting DOC who acknowledged the above observations and further indicated that all medications used by the residents in the home had to be prescribed by the most responsible physician in the home. The Acting DOC acknowledged that in resident #021's case, the home had failed to ensure that no drug had been used by a resident in the home unless the drug had been prescribed for the resident.

2. The licensee had failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

During stage one of the RQI, Inspector #653 had conducted an observation of resident #012 in an identified location of the home on an identified date and time. The inspector had observed multiple medications to be stored inappropriately and not locked.

The inspector had observed more multiple medications to be stored in an identified area of the home for resident #021.

An interview was held with resident #021 who stated that they had been self-administering their identified medication on a daily basis. The resident further indicated that they had been in the home a year, and that they had always been independent with their medications even prior to moving into the Long Term Care Home (LTCH).

A review of resident #021's most recent three month medication review was signed by the physician on an identified date. Subsequent orders on an identified date and an interview held with RPN #146, did not identify a physician's order for self-administration of medication was carried out for resident #021.

An interview was carried out where the Acting DOC indicated for residents who wish to self-administer medications, the home's expectation was for the physician to write an order for self-administration of medication. The Acting DOC acknowledged that in resident #021's case, the home did not ensure that the resident had a physician's order for self-administration of medications.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;
-no drugs were used by a resident in the home, unless the drug had been prescribed for the resident,
-no resident administers a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee had failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date and time Inspector #116 entered an identified home are and observed a medication cart to be stored in the hallway unsupervised. The Electrical Medication Administration Record (EMAR) screen was open to resident #009's medical administration record and visible to the public. The Inspector noted RPN #104, assigned to the cart was in a resident's room administering medications. RPN #104 returned to the cart at an identified time.

An interview as carried out with RPN #104 who indicated they were aware that they had left the EMAR screen open and indicated that the EMAR screen is to be locked at all times when not in use to ensure personal health information (PHI) of residents are kept confidential during and after medication administration.

An interview held with the DOC indicated that the staff are directed to ensure PHI is kept confidential and confirmed that RPN #104 did not ensure that resident #009's PHI was kept confidential, and access to resident records of personal health information, in accordance with the Act was fully respected and promoted.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

The licensee had failed to ensure that once Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee replied within 10 days of receiving the advice and responded to the Residents' Council in writing.

An interview was carried out with the Residents' Council President (RCP) #020 who indicated that the home does not respond to the Residents' Council (RC) concerns or recommendations within ten days in writing.

An interview was carried out with the home's Administrator #107, who stated that the RC concerns or recommendations are addressed by the applicable department and a written response within ten days should be provided to the RC.

An interview was carried out with the home SPS #130. The SPS and the Inspector #604 with Inspector # 724 reviewed the following RC minutes and concerns or recommendations

An interview was carried out with the home's SPS #130. Inspector #604 with Inspector #723 reviewed the RC minutes and concerns or recommendations for two identified moths. The residents expressed identified concerns that required a response.

The SPS reviewed the RC minutes binder and the home's responses and acknowledged that there was no evidence to indicate that the above concerns where addressed by the home and also acknowledged a written response had not been provided within ten days to the RC.

An interview was carried out with the home's Administrator who stated that the SPS is responsible for sending the RC's concerns, comments to them after the meeting to the administrator. The Administrator stated that the home is to reply to the RC within ten days. The Inspector reviewed the RC minutes for two identified months, and the Administrator acknowledge that the home did not complete a concerns, recommendations form for the concerns addressed during the identified months at the RC meeting and the home did not reply to the RC in writing with in ten days.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee had failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions including any changes and improvements identified in the review are implemented, and a written record is kept.

Inspector #604 reviewed the home's "Medication Incident Reports (IR) Form", for the period of March – May 2018, and there were a total of 27 medication incidents. The home's Acting DOC indicated the medication incidents were discussed in the "Medical advisory and therapeutics committee", which was last reviewed on June 13, 2018. A review of the "Medical advisory and therapeutics committee" under section E.2 indicated Medication Error Report (Handout). The inspector was unable to find evidence that the home had reviewed the 27 medication incidents for the quarter.

An interview was carried out with the home's Acting DOC #105 and Consultant #147, who indicated that they had not carried quarterly review and analysis of the incidents but had them down on a spread sheet for reference. The Consultant indicated that analysis of the medication incidents with an interdisciplinary team was not carried out and the home is in the process of ensuring that quarterly reviews are carried out related to medication incidents and adverse drug reactions.

Issued on this 2nd day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), JOVAIRIA AWAN (648), ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2018_718604_0006
Log No. / No de registre :	009728-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 27, 2018
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	York Region Maple Health Centre 10424 Keele Street, Maple, ON, L6A-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dianne Turcotte

To The Regional Municipality of York, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 must be compliant with r. 50. (2) (b) (iv) of the LTCH Regulation.

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement under the LTCH Regulation. Specifically, the plan must include:

a) All registered staff are to be educated on the home's Skin and Wound Care policy, specifically related to skin and wound care assessment.

b) Develop and implement an ongoing audit system to ensure that the all residents identified with alterations in skin receive weekly skin and wound assessments by a registered staff member.

c) The home shall keep documented records pertaining to part a and b of this order to present to the Inspector when requested.

Please submit the written plan for achieving compliance for inspection #2018_718604_0006, to Shihana Rumzi, LTC Homes Inspector, MOHLTC, by email to MOHLTCIBCentralE@ontario.ca, by October 9, 2018.

Grounds / Motifs :

1. The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home.

Resident #008 triggered through stage one of the Resident Quality Inspection (RQI) for an alteration in skin integrity through the census record review.

A review of resident #008's Point Click Care (PCC) assessments indicated on an identified date an alteration in skin integrity was identified. The Inspector reviewed the assessment and did not find evidence to show an identified assessment by the dietitian was carried out. Further review of the assessments showed that the registered dietitian carried out an assessment at a later time after the alteration in skin integrity was discovered.

An interview was carried out with RPN #115 who indicated that it was the home's expectation that when a resident was identified with an alteration in skin, an initial skin assessment is to be carried out on PCC and at the time the skin

issue was found a dietary referral is to be sent on PCC by the nursing staff in order for the registered dietitian to assess the resident. The Inspector and the RPN reviewed resident #008's assessments for an identified dates and a dietary referral was not completed until a later time after the alteration in skin integrity was identified. The RPN acknowledge that it was not acceptable that a dietary referral was sent later and a registered dietitian assessment was not carried out at the time the altercation in skin was identified.

An interview was carried out with the Acting DOC #105 who indicated that when a skin alteration is identified a skin assessment is to be completed and the nursing staff is to send a dietary referral. The Acting DOC and the Inspector reviewed resident #008's referrals and a dietary referral to the registered dietitian was no found until a later date. The Acting DOC acknowledged that the registered dietitian of the home did not assess resident #008's status related to the resident's skin integrity until a later date.

2. Resident #008 triggered through stage one of the RQI for an alteration in skin integrity through census record review. Areas of noncompliance was identified for resident #008 and the sample size was expanded.

An identified assessment was carried out for resident #046 which indicated that on an identified date an identified area of alteration in skin integrity was found.

A review of resident #046's assessment history for the alteration in skin integrity was carried out for an identified period and Inspector #604 was unable to find a registered dietitian assessment for the alteration in skin integrity.

An interview was carried out with the Supervisor of Care (SC) #126 who is also the home's Skin and Wound Lead (SWL). The SC stated that it was the home's expectation when a resident is found to have an alteration in skin integrity the registered nurse is to inform Physiotherapy (PT), and send a dietary referral on PCC, and a weekly skin assessment is to be carried out. The SC indicated resident #046 had an alteration in skin integrity which since had resolved. The SC and Inspector #604 reviewed the assessment table on PCC for an identified period when the resident was identified has having alteration in skin integrity. The SC acknowledged that a referral to the registered dietitian was not sent when resident #046 was found to have an alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that when

an area of altered skin integrity is identified a skin and wound assessment is to be completed and the nursing staff is to send referral to the dietary related when the site is identified to have the registered dietitian assess nutritional needs. The Acting DOC and the Inspector reviewed resident #046's referrals and a dietary referral was not found. The Acting DOC acknowledged that as the dietary referral was no found a registered dietitian did not carry out an assessment.

3. The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed and was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 triggered through stage one of the RQI for alteration in skin integrity through the census record review.

A review of resident #008's assessment on an identified date, indicated an identified alteration in skin integrity with no description of the alteration in skin integrity. Further review of assessments for alteration in skin integrity was carried out for an identified time period and Inspector #604 was unable to find a completed skin and wound assessment for resident #008's identified to have an alteration in skin integrity.

A review of resident #008's PCC progress notes were reviewed for an identified period related to the alteration in skin integrity and the inspector was unable to find any assessments.

On an identified date Inspector #604 carried out an observation with Registered Practical Nurse (RPN) #115, of resident #008's alteration in skin integrity and confirmed the alteration in skin integrity persisted.

An interview was carried out with RPN #115 who indicated that it was the home's expectation that when a resident was identified with an alteration in skin an initial assessment is to be carried out on PCC with a description of the alteration in skin, type of treatment, and interventions. The RPN also stated that a weekly skin and wound assessment is to be carried out until the skin has healed. The RPN stated resident #008 currently has an alteration in skin and a skin and wound assessment is to be carried out weekly. The RPN and Inspector #604 reviewed resident #008's assessments for an identified period of time and PCC progress notes. The RPN acknowledged that after reviewing the

assessments and the PCC progress notes that there were assessments opened but not completed for the alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that it was the home's expectation that a weekly skin and wound assessment be carried out on PCC when a resident is identified to have skin breakdown. The Acting DOC and the Inspector reviewed resident #008's skin and wound assessments for the dates indicated above. The Acting DOC acknowledged that after reviewing the skin assessments and the PCC progress notes that there were no weekly skin assessments completed for resident #008's alteration in skin integrity.

4. Resident #008 triggered through stage one of the RQI for an alteration in skin integrity through the census record review. Areas of noncompliance was identified for resident #008 and the sample size was expanded.

A "Skin and Wound" assessment was carried out for resident #046 indicating that on an identified date, an alteration in skin integrity was identified.

A review of resident #046's "Skin and Wound" assessment was carried out for an identified period and the Inspector was unable to find a completed skin assessments for the alteration in skin integrity.

An interview was carried with SC #126 who is also the home's new Skin and Wound Lead (SWL). The SC stated that it was the home's expectation when a resident is found to have an area of altered skin integrity the registered nurse is to carry out a weekly skin assessment thereafter until the area has healed. The SC indicated resident #046 had an alteration in skin integrity but has recently resolved. The SC and Inspector reviewed the skin and wound assessments on PCC from for an identified period when the resident was identified has having alteration in skin integrity and the SC acknowledged that a weekly skin and wound assessment was not completed for resident #046's alteration in skin integrity.

An interview was carried out with the Acting DOC #105 who indicated that when an area of altered skin integrity is identified a skin and wound assessment is to be completed weekly by the nursing staff. The Acting DOC and the Inspector reviewed resident #046's identified assessments from an identified period as indicated above and the Acting DOC acknowledged that an identified assessment was not completed for resident #046 on a weekly basis.

The severity of this issue was determined to be a level 2 as minimal harm/risk or potential for actual arm/risk as resident #008 and #046 did not receive weekly skin assessments for their identified pressure ulcers. The scope of the incident was a level 2 as it related to two of three residents reviewed. The home had a level 4 compliance history as they had ongoing noncompliance with LTC Regulation r. 50. (2) (b) (iv) which included:
-Voluntary Plan of Correction (VPC) issued November 28, 2016, (2016_414110_0012) (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 08, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Shihana Rumzi

Service Area Office / Bureau régional de services : Central East Service Area Office