Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2018_573581_0001	029300-17	Resident Quality Inspection

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760-14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Arbour Creek Long-Term Care Centre
2717 King Street East HAMILTON ON L8G 1J3

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

DIANNE BARSEVICH (581), JESSICA PALADINO (586), MELODY GRAY (123)

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): January 3, 4, 5, 8 and 9, 2018.

During the course of this inspection, the following additional inspections were conducted concurrently:

Critical Incident System (CIS):
#023647-17- related to unexpected death
#025035-17- related to falls prevention

Complaints:
#014057-17 related to personal care and falls prevention
#024942-17 related to falls prevention

During the course of this inspection, the following additional inquiry was conducted concurrently:
#033796-16 - related to resident and resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Physiotherapist (PT), Registered Dietitian (RD), Personal Support Worker (PSW), residents and families.

During the course of the inspection, the inspectors also reviewed resident clinical health records, incident investigation notes, policies and procedures, training records, toured the home, and observed resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified day in October 2017, progress notes documented that resident #040 was walked a short distance with a specific device and PSW #114 when an incident

occurred and the PSW staff lowered the resident to the ground and used the call bell to call for assistance. The resident was assessed and transferred by the mechanical lift. The following day, after complaining of increased extremity pain the resident was transferred to the hospital and was diagnosed with an injury.

Review of the written plan of care from October 2017, identified that resident #040 was to be transferred with two staff assistance for all tranfers. Review of the Lift and Transfer Mobility Assessment on an identified day in September 2017, identified they required a mechanical lift. On an identified day in September 2017, review of the Physiotherapy Quarterly Assessment indicated they were dependent on the staff for mobility, transferred with a mechanical lift and were non ambulant.

A review of the home's investigation notes, identified that PSW #124 was providing care and entered the resident's room. The PSW walked the resident a short distance with a specific device by themselves and an incident occurred and the resident was lowered to the floor.

Interview with PSW #124 stated that the resident was a two person assist transfer and they had in the past walked the resident short distances by themselves with a specific device with no concerns. Review of the written plan of care with PSW #124 confirmed they were a two person transfer for toileting, required a device for all mobility and there was no direction to the PSW staff that the resident was to be walked with the specific device for short distances.

Review of the PSW flow sheets identified the resident was transferred as followed;
i. For nine identified days in July 2017, the PSW staff documented the resident was transferred with two person physical assistance.
ii. During the month of August 2017, they were transferred on 20 different days with one person physical assistance.
iii. The month of September 2017, the resident was transferred 23 days with one person and 7 days with 2 person physical assistance.
iv. The month of October 2017, they were transferred 15 days with one person and 11 days with two person assistance.

Interview and review of the plan of care including the PSW flow sheets with RPN #107 stated that the resident was to be transferred with a mechanical lift after they sustained an injury in June 2017 until an identified day in August 2017 when the written plan of care was revised and identified the resident was to be transferred with two person assistance.

They confirmed that the PSW staff documented on the flow sheets that the resident was transferred on an identified day in July to an identified day in August and then four more days in August 2017, with two person physical assistance and for three identified day in days in August 2017, was transferred with one person assistance. On an identified day in August 2017, the written plan of care was revised an identified the resident was to be transferred with two person assistance; however the NM stated the resident was not assessed to be transferred with one person assistance. Further review of the PSW flow sheets identified after an identified day in August 2017, the resident was often transferred with one person assistance on both day and evening shifts including the identified day in October 2017, when they were transferred and walked with a specific device with PSW #124 and the resident sustained an injury.

Interview with the DOC and Nurse Manager stated that at the time of the incident on an identified day in October 2017, the resident was a mechanical lift with two staff for all transfers; however, the written plan of care was not updated to reflect this change and the resident should not of been walking with a specific device with staff or transferred with one staff assistance.

The DOC confirmed that PSW #124 did not use safe transferring techniques when assisting resident #040 on an identified day in October 2017 and they sustained an injury. [s.36.] (581)

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 failed to ensure where the Act or Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A. In accordance with Ontario Regulation 79/10, s. 52, required the licensee to ensure there was a program in place to manage pain. The home's policy and procedure, Pain Management, #RC-05-01-04, revised March 1, 2017, was reviewed and identified that residents who were at risk for pain were to be screened at least weekly. Ensure there was accurate and complete documentation using the Pain Assessment Flow Sheet in PCC. All residents that received PRN pain interventions were to be assessed after the intervention had reached peak effect.

The clinical health record of resident #017 who was identified as having a specific diagnosis was reviewed with NM and revealed there were no weekly pain assessments completed for the weeks starting on an identified day in November and December 2017. The NM stated the resident was being assessed weekly for pain management and confirmed that the staff did not complete and document the weekly pain assessments consistently for resident #017 as per the home's policy and procedure.

B. The clinical health record of resident #016 was reviewed and identified that the resident's care plan included a focus statement related to pain. The resident's assessments were reviewed and a pain assessment was not completed for the week starting on an identified day in December 2017. Interview and review of the plan of care with the NM and they confirmed that the weekly pain assessment was not completed and documented as per the home's policy and procedure.

C. The clinical health record of resident #013 included skin and wound issues and pain was reviewed. The resident did not have weekly pain assessments documented for the two week period during an identified time in December 2017. The NM was interviewed and confirmed the staff did not complete or document the weekly pain assessments above as per the home's policy and procedure.

D. In accordance with Ontario Regulation 79/10, s. 48, required the licensee to ensure there was a falls prevention and management program in place to reduce the incidence of falls and the risk of injury. Review of the home's policy, "Resident Client Falls", Policy No: RC-09-02-01, revised November 1, 2016, identified that when a resident had experienced a fall that the registered staff were to assess the resident including but not limited to checking the resident's vital signs and completing an incident report, adding name to fall tracking sheet, detailed progress notes and a risk management assessment.

Review of the clinical health record for resident #040 identified that on an identified day in October 2017, an incident occurred and they sustained an injury. Review of the post fall assessment and progress notes in PCC identified that the resident's vital signs were not assessed or documented. Interview and review of the plan of care with RPN #125 stated they did not take their vital signs when the incident first occurred, but thought they were taken when the resident was transferred back to bed; however confirmed they were not documented and the home's policy was not complied with.

Interview and review of the plan of care with the DOC stated the resident's name was not documented on the October 2017, Fall Tracking Sheet and confirmed that the home's policy was not complied with. [s. 8. (1) (b)] (123)

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 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, is complied with, to be implemented voluntarily.

WN #3: 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:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was 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.

Review of the plan of care for resident #017 identified they had a specific diagnosis and had a history of experiencing pain. The resident's written plan of care did not include any information related to actual or potential pain and no information related to their specific diagnosis. The NM was interviewed and confirmed the care plan was not based on an interdisciplinary assessment of the resident's pain and special needs related to the specific diagnosis. [s. 26. (3) 10.] (123)

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

The clinical health record of resident #017 including the care plan was reviewed and the resident was noted to have a history of altered skin integrity. The written plan of care did not include a focus related to actual or potential alteration of skin integrity. The resident's historical care plans were reviewed by the Nurse Manager and Long Term Care Homes (LTCH) Inspector and it did not include any information related to actual or potential altered skin integrity and the documentation reviewed included physician’s orders and skin assessments and MDS assessments. Interview with the NM confirmed that the plan of care was not based on interdisciplinary assessment with respect to the resident's skin integrity. [s. 26. (3) 15.] (123)

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs and that the plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept related to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home provided the LTCH Inspectors with the 2016 annual program evaluations (completed in 2017) for the following programs: skin and wound care, abuse prevention, responsive behaviours, fall prevention, pain management, restraint and PASDs. Review of the evaluation forms and interview with the NM on January 9, 2018, confirmed that the evaluations did not include a summary of the changes made and the dates that those changes were implemented. [s. 30. (1) 4.] (586)

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 written record is kept related to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #5: 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 failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The home's policy and procedure, Wound/Skin Reporting and Treatment, #RC-05-07-22D, revised February 5, 2017, was reviewed and included: Every wound must be assessed by the registered staff and documented on a weekly basis for wound condition, change dressing as required/needed.

The clinical health record of resident #017 was reviewed including the October and November, 2017 RAI-MDS assessments. The resident was noted to have altered skin integrity that was deteriorating. The weekly skin assessments were reviewed and there was no documentation of a weekly skin assessment completed from an identified day in September to an identified day in October 2017.
The Nurse Manager was interviewed and reported that it was the home's expectation that staff completed a weekly skin assessment using the appropriate instrument, while the resident had altered skin integrity. In early October 2017, the resident's health status started to decline, the resident's altered skin integrity deteriorated and the resident was sent to hospital on an identified day in October 2017 and returned to the home. The resident's altered skin integrity had deteriorated prior to hospitalization. The NM

confirmed that weekly skin assessments were not completed for resident #017 for approximately five weeks between an identified day in September to an identified day in October 2017.

On an identified day in December 2017, weekly skin assessment for resident #017 indicated that the resident had altered skin integrity. There was no evidence found that the resident received a skin assessment on or after an identified day in January 2018. Interview with the NM reported that registered staff documented in the treatment record that a skin assessment was completed; however, it was not. They confirmed that resident #017 did not receive a weekly skin assessment as required on an identified day in January 2018.

B. The clinical health record of resident #013 including the MDS assessment, care plan, weekly skin and wound assessment and weekly pain assessments were reviewed and identified they had an altered skin integrity on a specific location and there was no weekly wound assessment documented for the week starting on an identified day in November 2017. The NM was interviewed and confirmed that weekly skin and wound assessment was not completed. [s. 50. (2) (b) (iv)] (123)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: 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 :

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

On January 9, 2018, the medication cart was observed to be unlocked and unattended. The LTCH Inspector was able to open the medication cart. Residents were in the vicinity having lunch in the dining room. Registered staff #120 was not visible from the medication cart. The LTCH Inspector asked PSW staff where the registered staff #120 was and they indicated that the registered staff was on the other side of the dining room. The dining area was separated by a wall and the medication cart was not visible from the area where the registered staff #120 was located. The PSW called the registered staff #120 who later came and acknowledged the medication cart was unlocked and they locked the medication cart. [s. 129. (1) (a)] (123)

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 are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to 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.

Review of the Lift and Transfer Mobility Assessment on an identified day in June and an identified day in September 2017, identified resident #040 was transferred with the

mechanical lift for all transfers.

On an identified day in August 2017, the written plan of care was revised by registered staff and indicated that the resident was to be transferred with two person assistance. Interview with RPN #125 stated they updated the written plan of care without completing an assessment of the resident's transfers and confirmed the care set out in the plan of care was not based on an assessment of the resident and their needs. [s. 6 (2)] (581)

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #017's most recent Minimum Data Set (MDS) Assessment identified the resident was dehydrated. The Nurse Manager (NM) confirmed that dehydration would be coded if a resident's intake was consistently less than a specific amount of fluid servings. Review of the Resident Assessment Protocol (RAP) and interview with RPN #107 confirmed that the resident had poor fluid intake and that dehydration would be care planned and a referral sent to the Registered Dietitian (RD); however, that a referral was not sent.

In an interview with RD they indicated they were not aware that the resident had been coded for dehydration and that as per their nutritional assessments, they were not dehydrated as they were overall meeting their fluid needs. The RD also confirmed that they had not received a referral regarding this.

Staff did not collaborate with each other in the assessment of resident #017 related to their hydration status.

B. Review of the plan of care for resident #040 identified they fell on an identified day in June 2017 and sustained an injury and fell again on an identified day in October 2017 and sustained a different injury.

Review of the MDS assessment in November 2017, identified the resident had a fall in the past 30 days and an injury in the past 180 days; however, did not identify that the resident had a fall in the past 31 to 180 days or an injury in the past 180 days. Interview with RN #103 stated the resident had a fall and sustained an injury in June 2017 and confirmed that the MDS assessment and Resident Assessment Protocol (RAP) were not

integrated and consistent with each other. (581)

C. On an identified day in January 2018, resident #046 was observed being transferred with PSW #118 and #122 with a mechanical lift. Interview with PSW #122 stated the resident was transferred with the mechanical lift for all transfers. Review of the Lift and Transfer Mobility Assessment completed on an identified day in October 2017, indicated the resident was a two person transfer and a mechanical lift as needed. The home's Transfer and Lift Audit was reviewed and revealed the resident was a mechanical lift for all transfers. Interview and review of the plan of care with RPN #123 stated the resident was not a two person assist transfer, was transferred with the mechanical lift and confirmed that the Lift and Transfer Mobility Assessment and the Transfer and Lift Audit were not integrated and consistent with each other. (581) [s. 6. (4) (a)] (586)

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

Review of the MDS assessment on an identified day in November 2017, for resident #011 identified they had a restraint. Interview and review of the plan of care with RPN #107 stated that the resident required a specific device at that time as a PASD, not a restraint and they did not have a restraint. They confirmed that the MDS assessment and the written plan of care were not integrated and consistent with each other. [s. 6. (4) (b)] (581)

4. The licensee failed to ensure that the resident, the resident’s substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

On an identified day in October 2017, during morning care resident #040 sustained an injury. Review of the plan of care identified that the substitute decision maker (SDM) was not notified of the incident by the registered staff until the evening shift when it was documented a voice message was left and registered staff called again five hours later and did speak with the SDM about the incident. Interview with the SDM stated that they were told the resident fell and were not told that the incident occurred in the morning. They stated they would have requested that the resident be sent to the hospital sooner if they were notified earlier in the day. Interview with the RPN #125 who assessed the

resident after the incident stated that the SDM should have been notified on the day shift and confirmed that the SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)] (581)

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

On an identified day in June 2017, the Lift and Transfer Mobility Assessment identified that resident #040 was to be transferred with a mechanical lift after they fell and sustained an injury.
On an identified day in June 2017, the physiotherapist revised the written plan of care to identify that staff were to provide two person for constant supervision using the mechanical lift for all transfers.
On an identified day in August 2017, the written plan of care was revised and identified that resident #040 was to be transferred with two person assistance; however, there was no assessment completed.
On an identified day in October 2017, the resident was transferred and walked with one staff assistance when an incident occurred and they sustained an injury.

Interview with PSW #124 stated they often transferred the resident with one person assistance and walked them short distances with a specific device. They confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan when they transferred the resident with one staff and they sustained an injury.

Review of the PSW flow sheets identified the resident was transferred as followed;

i. For nine identified days in July 2017, the PSW staff documented the resident was transferred with two person physical assistance.
ii. During the month of August 2017, they were transferred on 20 different days with one person physical assistance.
iii. The month of September 2017, the resident was transferred 23 days with one person and 7 days with 2 person physical assistance.
iv. The month of October 2017, they were transferred 15 days with one person and 11 days with two person assistance.

Interview and review of the plan of care including the PSW flow sheets with RPN #107 stated that the resident was to be transferred with a mechanical lift after they sustained an injury in June 2017 until an identified day in August 2017 when the written plan of care

was revised and identified the resident was to be transferred with two person assistance. They confirmed that the PSW staff documented on the flow sheets that the resident was transferred on an identified day in July to an identified day in August and then four more identified days in August 2017, with two person physical assistance and for three identified day in days in August 2017, was transferred with one person assistance. On an identified day in August 2017, the written plan of care was revised an identified the resident was to be transferred with two person assistance; however the NM stated the resident was not assessed to be transferred with one person assistance. Further review of the PSW flow sheets identified after an identified day in August 2017, the resident was often transferred with one person assistance on both day and evening shifts including the identified day in October 2017, when they were transferred and walked with a specific device with PSW #124 and the resident sustained an injury.
RPN # 107 confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan related to transfers. [s. 6. (7)] (581)

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

A. Review of the progress notes and interview with RD on an identified day in January 2018, confirmed that the assessed fluid needs for resident #016 was a specific amount per day; however, their documented plan of care, which front line staff use to direct care, indicated that their fluid needs were 500 ml more per day. The RD acknowledged that their fluid needs had been changed from one specific amount per day to a lower amount per day during the last assessment and that the plan of care had not been updated when their care needs changed.

B. On an identified day in January 2018, the written plan of care was revised to identify that resident #011 required a restraint device for prevention of injury due to specific diagnoses. Interview and review of the clinical health record with RPN #116 stated the resident was reassessed on an identified day in November 2017, as requiring the device as a restraint and confirmed that the plan of care was not updated when the resident was assessed for requiring a restraint device.

C. Review of the plan of care for resident #011 identified they were assessed for a device as a PASD in June 2017 and the device was applied at specific times and as needed if the resident was demonstrating responsive behaviours. On an identified day in November 2017, the resident was assessed as requiring a specific device as a restraint.

Review of the electronic medical record (EMAR) with RPN #103 revealed the reassessment by the registered staff of the effectiveness of the restraining was to be evaluated at least every eight hours and confirmed that it was not updated to reflect that the resident now required the device as a restraint and no longer as a PASD at certain time periods and as needed.

D. On January 2018, resident #011 was observed with a specific device applied. Review of the plan of care identified the device was applied when needed or when they were not able to ambulate independently. They were also walked to a specific location with two person staff assistance. Interview with RPN #116 and review of the clinical record stated the resident was assessed as requiring the device as a restraint on an identified day in November 2017 and was no longer walking with two staff. They confirmed that the plan of care was not revised when the care set out in the plan was no longer necessary.

E. Review of the written plan of care between an identified day in August and an identified day in November 2017, for resident #040 indicated they were a two person transfer for all transfers. Review of the Lift and Transfer Mobility Assessment on identified day in September 2017, identified the resident was reassessed and required a mechanical lift with two staff for all transfers. Interview with RPN #107 stated that the resident was assessed to require the mechanical lift on an identified day in September 2017 and confirmed the plan of care was not reviewed and revised when the resident's care needs changed related to transfers. [s. 6. (10) (b)] (586).

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 is based on an assessment of the resident and the needs and preferences of that resident, that the resident, the resident’s substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care, that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan of care is no longer necessary, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a weight monitoring system was in place to measure and record with respect to each resident, body mass index and height on admission and annually thereafter.

The home’s policy, Resident Client Weight and Height, directed staff to measure each resident’s height on admission. The policy did not indicate that heights were to be taken annually thereafter.

During the inspection it was identified that residents' heights were taken and recorded on admission, but not annually. Records identified that 16 of 16 residents reviewed, who were in the home for over thirteen months, did not have their height completed on an annual basis. Interview with the Nurse Manager/RAI Co-ordinator on January 3, 2018, acknowledged and confirmed that residents' heights were taken on admission and on an as needed basis; however, were not done annually.

The home did not have a system in place to measure and record each resident’s height annually. [s. 68. (2) (e) (ii)] (586)

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 weight monitoring system is in place to measure and record with respect to each resident, body mass index and height on admission and annually thereafter, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or 36 of the Act, that staff applied the physical device in accordance with any manufacturer’s instructions.

The inspectors reviewed the manufacturer's instructions for identified physical devices

and noted application instructions and risks if the device was not applied as per the instructions.

The home's policy, Guidelines in Restraint and PASD Use, policy number: RC-08-01-28, last revised June 2, 2016, indicated that registered staff and PSW staff must ensure that the device was applied as per manufacturer's instructions as that may place the resident in danger.

A. On two identified days in January 2018, resident #011 was observed with a device applied, in a manner that was not as per the manufacturer's instructions. Review of the plan of care identified they required the device as a restraint due to specific diagnoses. On an identified day in January 2018, the LTCH Inspector observed the device with PSW #113. PSW #113 indicated in an interview that the device was not applied correctly. The PSW then adjusted the device on the resident. Interview with RPN #116 stated that the resident was unable to remove the device independently and required the device as a restraint.

Interview with a consultant who observed the device was not applied correctly on an identified day in January 2018, with PSW #113 and LTCH Inspector confirmed that the device was not applied correctly according to the manufacturer's instructions and adjusted the device.

B. On an identified day in January 2018, resident #042 was observed with a device applied in a manner that was not as per the manufacturer's instructions. Review of the plan of care identified they required the device as a restraint due to specific diagnoses. The LTCH Inspector observed the device with PSW #112. PSW #112 indicated in an interview that the device was not applied correctly. The PSW then adjusted the device on the resident.

C. On an identified day in January 2018, resident # 015 was observed with a device applied in a manner that was not as per the manufacturer's instructions. The LTCH Inspector observed the device with PSW #117. PSW #117 indicated in an interview that the device was not applied as per manufacturer's instructions. The PSW then adjusted the device on the resident.

D. On an identified day in January 2018, resident #016 was observed with a device applied not in a manner that was consistent with the manufacturer's instructions. Review of the plan of care identified they required the device as a restraint. Staff were to check

right away after applying and reapplying the restraint. The LTCH Inspector observed the device with PSW #100 and PTA #101, independently. They both indicated that they felt the device was appropriately applied and were not aware of any specific instructions on how to apply it, other than to ensure the resident was comfortable and it was properly.

RPN #102 confirmed through interview and observation of the device that the device was not applied correctly according to the manufacturer's instructions and they adjusted the physical device. (586) [s. 110. (1) 1.] (581)

2. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act and that the resident was released from the physical device and repositioned at least once every two hours.

A. Resident #015's documented plan of care and interview with the NM confirmed that they used a specific device as a restraint. An observation of the resident was completed on an identified day in January 2018, for over three hours and the device was not removed from the resident. In a review of the resident's restraint flow sheet with PSW #119, it was documented that the resident was toileted, checked, repositioned and checked again during that time period; however, PSW #119 confirmed that the restraint should have been removed every two hours. (586)

B. On an identified day in January 2018, resident #011 was observed with device applied for almost three and half hours and the resident was not repositioned or the device was not removed. Review of the plan of care identified they required the device as a restraint and the device was to be removed and the resident repositioned every two hours. Interview with PSW #118 confirmed they did not reposition the resident or release the device during the above time period. [s. 110. (2) 4.] (586)

3. The licensee failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Review of the plan of care identified that resident #042 required a device applied as a restraint. Review of the Electronic Medical Record (EMR) revealed that the effectiveness of the restraint was not evaluated by a physician or registered nursing staff at least every eight hours. Interview with RN #123 stated the home's process was to document the

assessment of the resident's condition on the EMAR confirmed that the effectiveness of the restraint was not evaluated or documented by registered staff every eight hours. [s. 110. (2) 6.] (581)

4. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and included every release of the device and all repositioning.

During the course of the inspection resident #011 was observed with a physical device applied. Review of the plan of care identified they required the device as a restraint for prevention of injury due to risk of falls and PSW staff were to check the device and document every hour, release and reposition every two hours.

Review of the Restraint Flow Sheet documentation revealed that PSW staff were to document under six codes for restraint use as follows:
i. Restraint was applied;
ii. Restraint was removed;
iii. Resident was positioned;
iv. Resident was toileted;
v. Restraint was checked and
vi. Restraint was not applied.

Interview and review of the home’s restraint flow sheet with the NM confirmed that there were no codes for the PSW staff to document the releasing of all physical devices including the device on the restraint flow sheet. NM stated the home would need to revise the form to include documentation of releasing of all physical devices used to restrain a resident and re-educate the staff on documentation of restraints. [s. 110. (7) 7.] (581)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or 36 of the Act and staff apply the physical device in accordance with any manufacturer’s instructions, that the following requirement is met where a resident is being restrained by a physical device under section 31 of the Act and that the resident is released from the physical device and repositioned at least once every two hours and that the resident’s condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident’s condition or circumstances and to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and included every release of the device and all repositioning, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident’s plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On two identified days in January 2018, resident #010 was observed with a PASD applied. Review of the plan of care did not identify they required a PASD. Interview with the NM stated the resident required the PASD with restraining effects and confirmed it should have been documented on the home's PASD assessment form and included in the plan of care. [s. 33. (3)] (581)

2. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

On two identified days in January 2018, resident #011 was observed with a specific device applied. Review of the written plan of care directed staff to remove the device and reposition the resident every two hours and to increase monitoring. Review of the clinical record indicated there was no documented assessment for the use of the device as a PASD, nor any documented consent or approvals for its use. Interview with RN #103 stated the resident required the device for repositioning and confirmed that the device was not assessed as a PASD, nor did they have documented consent or approval for its use. [s. 33. (4)] (581)

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 PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident’s plan of care and that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD has been considered, and tried where appropriate.
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of the following incidents in the home, followed by the report required under subsection (4): 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

On an identified day in October 2017, resident #020 was found deceased. In an interview with the NM on an identified day in January 2018, they confirmed that the resident's death was sudden and unexpected. The NM confirmed that they did not report the incident to the Director until two days later.
The Director was not immediately notified of a sudden and unexpected death. [s. 107. (1) 2.] (586)

Issued on this 8th day of February, 2018

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

Original report signed by the inspector.

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

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) :	DIANNE BARSEVICH (581), JESSICA PALADINO (586), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2018_573581_0001
Log No. / No de registre :	029300-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 8, 2018
Licensee / Titulaire de permis :	Rykka Care Centres GP Inc. 3760-14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Arbour Creek Long-Term Care Centre 2717 King Street East, HAMILTON, ON, L8G-1J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Paladino

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To Rykka Care Centres GP Inc., 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, including resident #040.

All staff shall review the home's transfer policies including but not limited to the mechanical lifts, one and two person transfers and documentation of this review must be kept, including the staff's signature and date of review.

All direct care staff shall be re-educated on the home's expectation that the written plan of care is followed related to how residents are transferred.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (3), in keeping with s.299 (1) of the Regulation, in respect of the actual harm that resident #040 experienced, the scope of one isolated incident, and the Licensee's history of related non-compliance in the area of improper transferring and positioning techniques with a Compliance Order on January 11, 2016.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified day in October 2017, progress notes documented that resident #040 was walked a short distance with a specific device and PSW #114 when an incident occurred and the PSW staff lowered the resident to the ground and used the call bell to call for assistance. The resident was assessed and transferred by the mechanical lift. The following day, after complaining of increased extremity pain the resident was transferred to the hospital and was

diagnosed with an injury.

Review of the written plan of care from October 2017, identified that resident #040 was to be transferred with two staff assistance for all tranfers. Review of the Lift and Transfer Mobility Assessment on an identified day in September 2017, identified they required a mechanical lift. On an identified day in September 2017, review of the Physiotherapy Quarterly Assessment indicated they were dependent on the staff for mobility, transferred with a mechanical lift and were non ambulant.

A review of the home's investigation notes, identified that PSW #124 was providing care and entered the resident's room. The PSW walked the resident a short distance with a specific device by themselves and an incident occurred and the resident was lowered to the floor.

Interview with PSW #124 stated that the resident was a two person assist transfer and they had in the past walked the resident short distances by themselves with a specific device with no concerns. Review of the written plan of care with PSW #124 confirmed they were a two person transfer for toileting, required a device for all mobility and there was no direction to the PSW staff that the resident was to be walked with the specific device for short distances.

Review of the PSW flow sheets identified the resident was transferred as followed;
i. For nine identified days in July 2017, the PSW staff documented the resident was transferred with two person physical assistance.
ii. During the month of August 2017, they were transferred on 20 different days with one person physical assistance.
iii. The month of September 2017, the resident was transferred 23 days with one person and 7 days with 2 person physical assistance.
iv. The month of October 2017, they were transferred 15 days with one person and 11 days with two person assistance.

Interview and review of the plan of care including the PSW flow sheets with RPN #107 stated that the resident was to be transferred with a mechanical lift after they sustained an injury in June 2017 until an identified day in August 2017 when the written plan of care was revised and identified the resident was to be transferred with two person assistance. They confirmed that the PSW staff documented on the flow sheets that the resident was transferred on an identified

day in July to an identified day in August and then four more days in August 2017, with two person physical assistance and for three identified day in days in August 2017, was transferred with one person assistance. On an identified day in August 2017, the written plan of care was revised an identified the resident was to be transferred with two person assistance; however the NM stated the resident was not assessed to be transferred with one person assistance. Further review of the PSW flow sheets identified after an identified day in August 2017, the resident was often transferred with one person assistance on both day and evening shifts including the identified day in October 2017, when they were transferred and walked with a specific device with PSW #124 and the resident sustained an injury.

Interview with the DOC and Nurse Manager stated that at the time of the incident on an identified day in October 2017, the resident was a mechanical lift with two staff for all transfers; however, the written plan of care was not updated to reflect this change and the resident should not of been walking with a specific device with staff or transferred with one staff assistance.

The DOC confirmed that PSW #124 did not use safe transferring techniques when assisting resident #040 on an identified day in October 2017 and they sustained an injury. [s.36.] (581)
(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2018

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 8th day of February, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Dianne Barsevich

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