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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 04, 2018;	2018_695156_0002 (A2)	001517-18	Resident Quality Inspection

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Billings Court Manor
3700 Billings Court BURLINGTON ON L7N 3N6

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

Amended by CAROL POLCZ (156) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Public report amended to remove date identifier.

Issued on this 4 day of May 2018 (A2)

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

Original report signed by the inspector.

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Amended by CAROL POLCZ (156) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 24, 25, 26, 29, 30, 31, 2018.

During this inspection the inspections listed below were conducted concurrently:

Critical Incident System (CIS) inspection:

032051-16 related to prevention of abuse and neglect

Complaints:

033393-16 related to prevention of abuse and neglect

004886-17 related to resident care, staffing

013727-17 related to medication administration

On-site inquiries:

005121-17 CIS related to late reporting of outbreak

005324-17 CIS related to late reporting of outbreak

005410-17 CIS related to prevention of abuse and neglect

005719-17 CIS related to prevention of abuse and neglect

014187-17 CIS related to prevention of abuse and neglect

012984-17 CIS related to prevention of abuse and neglect

030172-16 CIS related to prevention of abuse and neglect

029729-17 complaint related to pest control

027878-17 complaint related to care concerns and prevention of abuse and neglect

001337-18 complaint related to allegations and continence

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Quality Care Coordinator, Resident Assessment Instrument Coordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), Housekeeping Supervisor, Personal Support Workers (PSWs), dietary aides, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dining Observation

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Skin and Wound Care

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

- **15 WN(s)**
- **8 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times.

A) On an identified date in January, 2018, the Long Term Care Home (LTCH) Inspector attempted to activate two different resident room call bells on an identified home area, however, the call bells did not activate. This was brought to the attention of registered staff #100 who confirmed that the call bells were not working, that they were not aware of the concern until brought to their attention by the Inspector and they were unsure how long the call bells were not working. The staff member called Maintenance who reported that the call bells were not pushed in far enough to activate. This was corrected at the time allowing the call bells to be activated.
2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, clearly indicated when activated where the signal was coming from.
B) On an identified date in January, 2018, in an identified home area, registered staff #113 on the unit confirmed that the staff use pagers to identify which call bells were activated. PSW's #123 and #134 confirmed that they had pagers and the

other two PSW's on the unit did not have pagers with them.
C) A complaint which was conducted simultaneously with the RQI inspection also identified that call bells were not answered in a timely manner.
On an identified date in January, 2018, as confirmed by the PSW's on their respective home areas,
i) On an identified home area two out of four PSW staff did not have working pagers.
ii) On another identified home area two out of four PSW staff did not have working pagers.
The following day in January, 2018, as confirmed by the PSW's on the respective home areas,
i) On an identified home area one out of four PSW staff did not have a working pager.
One day later, in January, 2018, as confirmed by the PSW's on the respective home areas,
i) On an identified home area two out of four PSW staff did not have working pagers.
ii) On another identified home area, two out four PSW staff did not have working pagers.
iii) On another identified home area, two out four PSW staff did not have working pagers.

The home policy "Resident staff communication and response system" CN-R16-1 dated July 2013 indicated that the home would provide sufficient number of ascom phones and pagers so that each nursing staff working had one to use and to ensure that each nursing staff carried a functioning ascom phone or pager while on duty. The home would maintain the ascom phones and pagers in working condition and arrange for repairs to pagers/ascom phones in a timely fashion. The policy indicated that PSW's would carry a functioning pager while on duty. All nursing and PSW staff were to sign a pager agreement (PSW) or a pager/ascom agreement (registered).

Interview with the Administrator, confirmed that all PSW and nursing staff were to carry pagers regardless if on a PSW team or not and that each PSW should have their own. The Administrator confirmed that they should have additional back up pagers for use by staff, however, at the time they did not have any back up pagers and that new ones were on order.
Interview with the Administrator confirmed that the new pagers that were ordered were still not in the home on the last day of the inspection.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, could be easily accessed and used by residents, staff and visitors at all times and clearly indicated when activated where the signal was coming from. [s. 17. (1) (a)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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 :

(A2)
1. 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; (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Review of the progress notes by RPN #499, on an identified date in June, 2017, identified resident #040 had a change in their condition. The day RPN indicated the next shift was to assess and monitor the resident. Further review of resident #040's medical condition documentation identified the results of a clinical test and their condition was still a concern. The documentation was unclear on which registered staff, #499 or #500, obtained and documented the results of the clinical test. There was no documentation in the resident's clinical record that indicated the resident was reassessed or their care needs were monitored by RPN #500 who worked the following shift. The the following morning, RN #501 assessed resident #040 and transferred them to hospital.

Resident #040 had an identified condition and change in their health status. The resident was treated while at the hospital.

Review of the progress notes, included the physician's documentation that an identified RPN failed to advise the charge nurse or the physician of the results of the clinical test for resident #040.

A review of the home's internal investigation notes contained an interview with RPN #500 that indicated they had checked the resident's clinical test results on an identified date in June, 2017, at the time of the medication pass. RPN #500 was documented to have stated that they were unsure of what the results meant and did not feel it needed to be reported. RPN #500 stated they checked the resident during the night and the resident appeared to be sleeping.

The DOC stated RPN #500, was unsure of what the results of the test meant and failed to perform an assessment, contact the physician or the Registered Nurse on duty. The DOC identified that the result of the test would be considered a critical value and that the RPN was required to review and revise resident #040's plan of care when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Billings Court is a long term care home with a licensed capacity of 160 beds. The planned staffing pattern for RN's in the home, for direct care of residents, is one RN on the day shift (twelve hours) and one RN on the night shift (twelve hours). The home also utilizes a mix of RPNs and personal support workers to meet the nursing and personal care needs of residents. Interview with the Administrator identified that the home does have a sufficient number of RNs on staff to fill all of the required shifts in the staffing plan; however, occasionally due to illness there are times when the home has vacant shifts which need to be filled. It was identified that the home consistently offers additional shifts to regular RNs to fill these vacant shifts and offers overtime. However, when the RNs employed by the home are unwilling or unable to work the vacant shifts the home may fill the required shifts with RNs employed with an employment agency, to ensure that there is a RN onsite 24 hours a day seven days a week. On request, the Administrator and DOC provided a list of the shifts worked by agency RNs, when they were the only RN in the building, beginning on an identified date in September 2017, until an identified date in January, 2018. It was identified that there were a total of five shifts when the home had only one RN in the building, an agency RN, who was not a member of the regular nursing staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

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 there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

WN #4: 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 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.

A) In accordance with O. Reg., s, 48(1) 2 the licensee is required to develop and implement a skin and wound care program.
In accordance with O. Reg., s, 30 (1) 1 the licensee is required to have written policies, procedures and protocols for the interdisciplinary programs required under section 48 of the Regulations.

The licensee failed to ensure staff complied with the licensee's policy and procedure identified in the "Skin Care and Wound Care Program: Wound Care Management" identified as CN-S-13-1 and last updated in February 2015. The above noted document included a procedure for the assessment of residents who

exhibit altered skin integrity and directed staff to complete:
1. A wound assessment protocol completed by Registered Nursing Staff upon discovery of a wound.
2. Have a wound care referral forwarded to the skin care co-ordinator.
3. Have a dietary referral forwarded to the dietitian.
4. Have treatment orders confirmed with the physician as per staging wound protocol.

Resident #003 was observed and noted to have an area of altered skin integrity. A review of the clinical record was completed and the inspector was not able to locate the required information. The ADOC confirmed that the home did not follow their policy and procedures regarding skin and wound management as none of the above identified items were completed for resident #003 until the LTC Homes Inspector identified that the resident had an area of altered skin integrity. [s. 8. (1) (b)]

2. B) In accordance with O. Reg., s, 114 (1) the licensee is required to develop and implement an interdisciplinary medication management system that provides for safe medication management.

i. Policy "Documentation" identified as CN D 17 1 stated documentation must be clear, concise, current, comprehensive and complete. Documentation provided for continuity of care by documenting assessment, plan, intervention and evaluation.

A review of resident #040's January 2018, Medication Administration Record (MAR) identified the resident required a clinical test be conducted four times a day. Further review of the MAR identified check marks at 0800, 1200, 1700 and 2100 hours for 26 days in January. There were no clinical test results documented on the MAR or the vital signs section of the clinical record. Further review of the clinical record identified inconsistent documentation of the actual clinical test result in the progress notes and the time of the documentation was not consistent with the check marks in the MAR.
Interview with the DOC, after they reviewed the documentation on the MAR, stated the check marks did not meet the home's expectation for clear, concise and comprehensive documentation of the resident's clinical test results.

ii. Policy "Ordering and Receiving Medications, SmartMeds Pharmacy" number 4-5 stated that when writing a new order, the date and time the order was prescribed should be documented and the doctor or transcribing nurse must provide a

signature.

a) Policy "Ordering and Receiving Medications, SmartMeds Pharmacy" number 4-5 stated that when writing a new order, the date and time the order was prescribed should be documented and the doctor or transcribing nurse must provide a signature.
A review of the Physicians Order form on an identified date in January, 2018, documented an order for an identified medication, immediately, for resident #040 but had not contained a date or time on the Physician Order form. Interview with RPN #114 stated they were told during the morning shift change on the identified date in January, 2018 that the medication was provided previously.
Interview with the DOC, following a review of the record, they stated the home's expectation for safe medication management would be that a new order would have a date and time on the Physician Order form.

The home's policy for Ordering Medications and the policy for clear, concise and comprehensive documentation was not complied with.

b) Resident #040 received an identified medication. A review of the clinical record identified RPN #499 performed a clinical test on an identified date in June, 2017 at 1600 hours and documented the results. Further review of the resident's progress notes indicated at 1846 hours, RPN #499 notified the physician and was advised and administered a medication. The progress note did not identify the specific medication. However, the same RPN, signed the MAR at 1700 hours on an identified date in June, 2017, for an identified medication if certain test results were obtained. This medication administration documentation omitted the dose and the administration instructions.

Further review of the Physician's Order form did not identify an order for medication on an identified date in June, 2017. The last physician order was received two days prior for an identified dose of a medication for an identified test result.

Further review of the June 2017, MAR, included direction for an identified medication, dose and administration for identified test results. If the results of the clinical test were greater than an identified amount, staff were to call the physician.

Interview with the DOC indicated there was no physician order documented on the physician's order form for the dose of medication administered, as identified and documented in the progress notes by RPN #499 on an identified date in June,

2017. The RPN was unavailable for interview. The DOC, reviewed the progress notes and MAR and stated RPN #499 would have taken a verbal order from the physician and forgot to document the order on the Physician Order Form. RPN #499 had not complied with the home's policy for "Ordering and Receiving Medications" when they failed to document an order as they identified in resident #040's progress notes.

iii) Policy "Medication Incident or Adverse Drug Reaction Reporting" number CN-M-03-1 stated that when a medication incident occurred the registered staff involved would complete a Medication Incident report. If another registered staff discovered the incident, they would initiate the medication report with as much information as possible and the person involved would finish the report. All applicable areas of the report are to be completed by the registered staff and then the report is sent to the DOC/ADOC for review. Notifications are completed and any additional reports are done within the timelines of the reporting policy.

Resident #043 was on identified medication.

A review of the PAC minutes dated for May, 2017, identified the DOC reported a "medication incident" involving resident #043. The minutes described that medication was found in the resident's possession and the resident's known behaviours. The Medication Incident report was not completed. The PAC minutes indicated the incident was managed internally and there had been no further incidents.

On interview with the DOC they stated they believed the resident was left unsupervised after being provided their medications and the medications were not taken. The DOC confirmed the home's Medication Administration policy stated the administration of medication required the staff to remain with the resident while they took the medication and to never leave a drug with a resident. The DOC further stated that omission of medication and leaving medications unsupervised with resident #043 would be a Medication Incident as defined in the above policy and the Medication Incident Report should have been completed.

The DOC stated they had not initiated the Medication report as required in the home's Medication Incident or Adverse Drug Reaction Reporting policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 #5: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #030 from emotional abuse.

In accordance with O. Reg. 79/10, s. 2 (1) emotional abuse is defined as "any any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident".

The Administrator, the Director of Care and documentation provided by the home confirmed that on an identified day in November, 2016, they received a complaint that alleged resident #030 had been verbally abused by PSW #125. The allegation was subsequently confirmed following the home's investigation.

Resident #030's plan of care included care focuses related to the resident's responsive behaviours and care needs.

The licensee failed to protect resident #030 and potentially other residents from emotional abuse when:
1. They failed to ensure that all staff received the required training in the areas of; the licensee's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26, for the 2016 and 2017 calendar years. The Administrator, DOC and training documents provided confirmed that 24 percent of all staff had not received the required training in 2016 and 19 percent of all staff had not received the required training in 2017.
2. They failed to ensure that actions were taken to prevent a recurrence of the above noted incident or similar incidents with other residents with the PSW. The Administrator and the Director of Care confirmed that they had not instituted a monitoring or oversight plan to ensure PSW #125 was providing appropriate care to residents and communicating with residents they were assigned to provide care to in an appropriate manner. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The plan of care for resident #005 indicated that staff were to provide twice weekly and prn (as needed) bathing as per bath schedule. Staff were to refer to bath/shower schedule for specific days and times.
A review of the bathing records indicated that the provision of the shower to the resident was not documented for three dates in November, 2017; and two dates in December, 2017.

B) The plan of care for resident #007 indicated that staff were to provide twice weekly and prn (as needed) bathing as per bath schedule. Staff were to refer to bath/shower schedule for specific days and times.
A review of the bathing records indicated that the provision of the shower to the resident was not documented for three dates in November, 2017; and two dates in December, 2017 and one date in January, 2018.

Interview with registered staff #117 and the RAI Coordinator confirmed that residents receive their scheduled two baths per week, however, if the home is not able to be staffed according to the planned staffing plan, the bath is made up at a later time that day or during the week and that staff had failed to document the provision of care. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident, including assessments, reassessments, interventions, and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #7: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) On an identified date in January, 2018, resident #003 was observed by the LTC Homes Inspector to have a treatment to their skin. A review of the resident's clinical record the following day did not include an assessment of this area. The ADOC confirmed on January 29, 2018, that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound until the LTC homes Inspector identified that one was not completed. [s. 50. (2) (b) (i)]

2. B) On an identified date in January, 2018, resident #001 was observed by the LTC Homes Inspector to have an alteration in their skin. A review of the resident's clinical record, did not include an assessment of this area. The ADOC confirmed, that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound until the LTC homes Inspector identified that one was not completed. [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that a 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.

Resident #001 developed altered skin integrity on an identified date in November, 2017. At the time of the inspection the area had been healing. A review was completed of the weekly skin assessments from November, 2017, until January, 2018. The review identified that an assessment had not been completed on one identified date in November, one identified date in December, 2017 and two identified dates in January, 2018. The Assistant Director of Resident Care (ADOC) confirmed that weekly assessments were not completed on the dates identified. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10 s. 221(2)1 staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The licensee failed to ensure all staff received annual training as required in the area of abuse recognition and prevention.

The Administrator, the Director of Care and training records provided by the home confirmed that 51 (24%) of 208 staff had not received training in the area of abuse recognition and prevention in the 2016 calendar year. Training records provided and confirmed by the Administrator and Director of Care also confirmed that 52 (19%) of 264 staff had not received the required training in the above noted area in the 2017 calendar year. [s. 76. (7) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff received training as required in the areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the provisions afforded by section 26. (s. 76 (2) 3, 4, 5), to be implemented voluntarily.

WN #9: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the medication administration observation, on an identified date in January, 2018, resident #042 was observed to receive multiple oral medications from RPN #114 at an identified time. RPN #114 stated due to a routine, the resident would receive their once a day medications not at 0800 hours. On review of the Medication Administration Record for resident #042 it was noted the daily medications administered were to be administered at 0800 hours. The medications were administered at an identified time.
Interview with the pharmacy provider, for the home, confirmed that daily medications were reviewed with the prescriber and daily medications were to be administered at 0800 hours and should the resident require a different time for daily medications it would be communicated to the prescriber and updated in the resident Medication Administration Record.
The licensee failed to ensure that resident #042's medications, that were administered at an identified time on the identified date were administered in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of the home's quarter two and quarter three medication incidents were reviewed as provided by the DOC. An identified number of Medication Incident Reports were identified to be initiated but not completed. Portions of the form that were not completed included pharmacy immediate actions taken, managers response, family notification and actions taken to prevent re-occurence. Signature lines on the form had not been completed for the manager, medical director, pharmacist and DOC on some of reports.

A review of the Professional Advisory Committee minutes did not indicate that each of the medications incidents were reported to the the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. Interview with the DOC stated the medication incidents were not reported in detail at the PAC meetings and the resident's SDM's had not been notified of each incident. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy "Abuse-Prevention, Reporting and Elimination of Abuse and Neglect", identified as CA-05-37-1-13 was not complied with.

The above noted policy directed:
1. "Administrator and/or designate shall notify the resident's family members, substitute decision makers or others specified in the resident's plan of care, within 12 hours after Administrator was made aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident."

The Administrator and the Director of Care confirmed that this direction had not been complied with when there was no documentation in resident #030's clinical record to verify that the resident's substitute decision maker was notified within 12 hours after the Administrator received an allegation that resident #030 had been abused by PSW #125.

2. "The Administrator shall submit a final report to the Ministry of Health and Long Term Care (MOHLTC) that outlines the findings of the investigation and corrective action taken."

The Administrator confirmed this direction had not been complied with when they had not submitted an amended Critical Incident Report (CIR) that outlined the findings of their investigation or corrective actions taken related to an allegation of abuse of resident #030 by PSW #125 in November, 2016. The Administrator confirmed they had not notified the MOHLTC in any other way of the outcome of the investigation or corrective actions taken following the above noted investigation. [s. 20. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Interview with the DOC and MDS RAI Coordinator reported that the Bowel and Bladder Assessment was completed on a quarterly basis or when there was significant change. The Bowel and Bladder assessment for an identified date in September, 2017, for resident #006 indicated that the resident had altered continence once a week or less. The MDS RAI section H Continence in the last 14 days, question 1 completed in December, 2017, indicated that the resident was coded as a having altered continence - multiple daily episodes. This significant change in bladder continence was not reassessed using the bowel and bladder assessment tool as confirmed during interview with the DOC and RAI Coordinator. The resident did not receive an assessment that included causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident.

The Administrator and documentation provided by the home confirmed an allegation that resident #030 was abused by a PSW on an identified date in November, 2016, when the staff person was allegedly overheard. Clinical documentation and investigative notes provided by the home indicated that resident #030 was not physically harmed, did not demonstrate behaviour that may have indicated distress and as a result due to their status would not likely have suffered any distress that could have been detrimental to their health. Clinical documentation indicated that as a result resident #030 was not their own decision maker and had a designated decision maker.
The Administrator and the Director of Care confirmed that there was no documentation in the clinical record to verify that resident #030's substitute-decision maker was notified within 12 hours of the licensee becoming aware of the above noted incident of resident abuse. [s. 97. (1) (b)]

WN #14: 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. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. Following a report made by the licensee under The Long Term Care Home Act 2007, c. 8, s. 23(1)(a), the licensee failed to make a preliminary or final report to the Director related to the analysis and follow-up actions, specifically; the long-term actions planned to correct the situation and prevent recurrence of resident abuse.

The licensee submitted a Critical Incident Report (CIR) to the Ministry of Health and Long Term Care in November, 2016, which indicated they had received a compliant related to an alleged incident of staff to resident verbal abuse. The CIR submitted on the same day as the alleged incident did not identify what long term actions were planned to correct the situation and prevent a recurrence.

The Administrator confirmed they had not notified the Director, as required, when they had not submitted an amended CIR following the outcome of their investigation into the allegation of resident abuse, or in any other way informed the Director of what actions were planned or implemented to correct the situation and prevent a recurrence of the incident. [s. 104. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

On an identified date in February, 2017, Public Health declared an outbreak in the home. A Critical Incident (CIS) was not filed to the Director until six days later.

On an identified date in March, 2017, Public Health declared an outbreak in the home. A CIS was not filed to the Director twenty five and a half hours later.

The Director of Care (DOC) confirmed that the Director was not informed immediately of an outbreak of a reportable disease on both dates in February and March, 2017. [s. 107. (1) 5.]

Issued on this 4 day of May 2018 (A2)

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

Ministère 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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by CAROL POLCZ (156) - (A2)

Inspection No. / No de l'inspection : 2018_695156_0002 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001517-18 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 04, 2018;(A2)

Licensee / Titulaire de permis : Maryban Holdings Ltd.
3700 Billings Court, BURLINGTON, ON, L7N-3N6

LTC Home / Foyer de SLD : Billings Court Manor
3700 Billings Court, BURLINGTON, ON, L7N-3N6

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

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

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that all residents that require a specific medication will be:
a) Assessed and identified for their risk level for developing a condition. This risk level will be documented in the resident's plan of care.
b) Each resident will be monitored, reassessed and the plan of care revised when the resident's care needs change or the resident shows signs or symptoms of the condition.
c) Resident's requiring a specific test will have it accurately documented in the clinical record with the time, value, action taken and registered staff signatures.
d) Registered staff will immediately notify the physician when a resident's test results are identified at a specific value.
e) The home shall educate all registered staff on the home's testing equipment and what specific values mean.
f) The home shall include directions for the equipment use and education, provided in the manufacture booklet, in the orientation for all newly hired registered staff members and will include examples of specific value reading and need to take action.

Grounds / Motifs :

1. 1. This Order is based on the application of the factors of severity (3), scope (1) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm experienced, the scope of isolated and the licensee's history of a VPC on September 19, 2016, June 2, 2015 and July 11, 2014.

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; (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Review of the progress notes by RPN #499, on an identified date in June, 2017, identified resident #040 had a change in their condition. The day RPN indicated the next shift was to assess and monitor the resident. Further review of resident #040's medical condition documentation identified the results of a clinical test and their condition was still a concern. The documentation was unclear on which registered staff, #499 or #500, obtained and documented the results of the clinical test. There was no documentation in the resident's clinical record that indicated the resident was reassessed or their care needs were monitored by RPN #500 who worked the following shift. The the following morning, RN #501 assessed resident #040 and transferred them to hospital.

Resident #040 had an identified condition and change in their health status. The resident was treated while at the hospital.

Review of the progress notes, included the physician's documentation that an identified RPN failed to advise the charge nurse or the physician of the results of the clinical test for resident #040.

A review of the home's internal investigation notes contained an interview with RPN #500 that indicated they had checked the resident's clinical test results on an identified date in June, 2017, at the time of the medication pass. RPN #500 was documented to have stated that they were unsure of what the results meant and did not feel it needed to be reported. RPN #500 stated they checked the resident during the night and the resident appeared to be sleeping.

The DOC stated RPN #500, was unsure of what the results of the test meant and failed to perform an assessment, contact the physician or the Registered Nurse on duty. The DOC identified that the result of the test would be considered a critical value and that the RPN was required to review and revise resident #040's plan of care when their care needs changed. [s. 6. (10) (b)] (156)

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

Ontario

Ministry of Health and Long-Term Care

Ministère 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

Mar 30, 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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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 4 day of May 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CAROL POLCZ - (A2)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Service Area Office / Bureau régional de services : Hamilton