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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 2, 2017	2017_642606_0008	008169-17	Other

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road MISSISSAUGA ON L4T 4M1

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

JANET GROUX (606), DIANE BROWN (110), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): April 27, May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, and 26, 2017.

The following complaints were inspected during this RQI inspection.

Log #030931-16 related to improper hydration; allegation of abuse; improper care and lack of assessment.
Log #030983-16-related to injury of unknown cause and allegation of neglect.
Log #000162-17-related to allegation of neglect; plan of care not provided; improper hydration; lingering offensive odours and feeding assistance not provided.
Log # 00366-16 related to Falls prevention and management, allegation of abuse, resident care.
Log # 030058-16 related to improper care/ Transferring and positioning and the handling of complaints.

The following Critical incident was inspected during this RQI inspection.
Log #030882-16 related to allegation of abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Supervisors of Care (SOC), Registered Dietitian (RD), Nurse Practitioner (NP), Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Services Manager (ESM), Facility Supervisor (FS), Facility Aide (FA), Director of Dietary Services (DDS), Food Service Supervisor (FSS), Dietary Team Lead, Dietary Aides (DA), Personal Care Attendants (PCA), Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of the Family Council (FC), minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
3 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. 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 the hydration program includes to monitor and evaluate the food and fluid intake of residents with identified risks to nutrition and hydration.

Two complaints were received by the Ministry of Health and Long-Term Care (MOHLTC), related to resident #001

Record review of resident's plan of care during an identified time in 2016, identified resident #001 at risk for fluid output exceeding intake characterized by a fluid deficit related to a number of identified factors. The plan of care directed staff to encourage a fluid consumption of an identified amount per day to meet minimum hydration needs and for registered staff to monitor for signs of fluid deficit and inform the RD, MD/NP if signs/ symptoms were noted.

Record review identified that the resident was assessed, by the NP, upon family request. The assessment plan included an order for an identified medical intervention to rehydrate

and lab work. On an identified date, the lab work revealed critical values and the resident was transferred to the hospital.

A review of the identified hospital's consultation report on an identified date revealed that resident #001 was admitted with identified medical conditions.

Staff interviews with PCA #129, #128 and #110 identified that resident #001 was a poor drinker. Interviews further revealed that fluid monitoring was completed by PCA's entering the number of servings of fluid the resident consumed into the Point of Care (POC) for each meal and snack plus any extra fluid was also identified. Staff revealed that Point Click Care (PCC) triggers an alert when the resident's fluid intake was below their fluid requirement for three consecutive days.

Record review of the progress notes between two identified dates, indicated five alerts related to decreased fluid intake for resident #001.

An identified home's referral form directed registered staff to refer to the RD when a resident was identified with a decreased fluid intake as per intake records and/or risk of dehydration.

The home's Dietary Services, Nutrition and Hydration Program stated the following:
The RD will determine fluid needs and fluid target levels following an assessment. An alert will be generated in the health electronic record (HER) when the resident consumes less than the target fluid intake for three consecutive days. Alerts are monitored by the RN/RPN with appropriate follow up and referrals as needed.

Interview with RPN #103 revealed that the POC generated an alert when the resident consumed less than the recommended intake for three days and otherwise he/she does not monitor the intake records. RPN #103 identified that the RD establishes the recommended fluid amount for the resident and a referral to the RD when they receive the prompt. Staff interviews and record reviews identified that a referral was not sent to the RD for fluid evaluation for the above noted alerts.

Record review of an identified home's report between two identified dates indicated 12 additional periods, of three consecutive days, whereby the resident did not meet his/her daily fluid requirement that did not trigger a POC alert.

Interview with RPN #103, RD and SOC #104 confirmed that a referral should have been

sent to the RD as part of monitoring and evaluating the resident’s fluid intake. They further confirmed the additional periods of three consecutive days whereby the system did not prompt an alert of poor fluid intake, for the purposes of fluid monitoring and evaluation. [s. 68. (2) (d)]

2. Record review of resident #003's current plan of care identified the resident at risk for fluid deficit related to a number of health and medical conditions. The plan of care directed staff to provide an identified amount of fluids at each nourishment and encourage to drink an identified amount of fluids to meet minimum fluid requirement and to monitor for signs of fluid deficit and follow-up with the MD/RD as needed.

Interview with RPN #132 revealed that the POC generates an alert when the resident consumes less than half and that he/she refers to the RD when a residents intake is poor.

Record review of an identified home's report for an identified time period revealed on an identified date, when the resident met his recommended fluid intake and that all other days residents intake was below an identified servings of fluid.

Review of progress notes between an identified time period revealed no clinical triggers, POC alerts, for decreased fluids.

Interview with the SOC #104 confirmed that resident's intake reported on an identified home's report was below his/her estimated identified amount of servings and that the POC did not trigger an alert for decreased fluids as expected.

Interview with the RD revealed there was no trigger set up for resident #003 in PCC and confirmed that fluid intake was not being monitored. [s. 68. (2) (d)]

3. Record review of resident #004 current plan of care identified the resident at risk for fluid deficit related to identified medical conditions. The plan of care directed staff to provide fluids as per menu plan and encourage an identified minimum amount of fluids to meet minimum fluid needs and to monitor resident for signs of fluid deficit.

Interview with RPN #132 revealed that the POC generates an alert when the resident consumes less than half and that he/she refers to the RD when a residents intake is poor.

Record review of an identified home's report on an identified time period revealed no days where resident meet his/her minimum fluid goal of an identified amount of fluids.

Review of progress notes between an identified time period revealed no clinical triggers, POC alerts, for decreased fluids.

Record review identified resident was transferred to the hospital and returned to the home on an identified date with an identified discharge diagnosis including an identified fluid deficit.

Interview with SOC #104 confirmed that resident's intake reported on an identified home's report was below his/her estimated servings and that the POC did not trigger an alert for decreased fluids as expected.

Interview with the RD revealed the wrong trigger was set up in POC as resident #004's fluid requirement and therefore did not alert at the correct identified amount. The RD confirmed that resident #004's fluid intake was not evaluated.

The scope of this non compliance is widespread. Three out of three residents reviewed were identified in non-compliance.

The severity of the non-compliance and the severity of the harm and risk of further harm is potential for harm.

The home does not have compliance history under the LTCHA, 2007, 68. (1) (d). [s. 68. (2) (d)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

Review of a complaint reported allegations of improper care/transfer of resident #022 resulting in an injury to an identified part of the body of unknown cause.

Review of resident #022's plan of care indicated the resident was at risk for falls characterized by history of falls/ injury, and had multiple risk factors. Further review of resident #022's progress notes indicated resident was found in an identified position in ian identified area of his/her room by PCA #112 at an identified time and was not witnessed by staff.

Review of resident #022’s plan of care revised on an identified date indicated the resident had several identified responsive behaviours. The plan of care provided staff interventions to manage the responsive behaviours and further indicated that if the interventions does not work, staff were to initiate further interventions specific to the responsive behaviours.

Interview with PCA #113 revealed he/she was called by PCA #112 to assist him/her to provide care to resident #022 on an identified date after the resident had finished an identified meal. He/she was informed by PCA #112 that the resident was displaying a specific responsive behaviour and that PCA #112required assistance. The PCA indicated resident #022 continued to have the identified responsive behaviour while he/she and PCA #113 provided care.

Interview with PCA #112 indicated resident #022 was provided care during the the identified time because he/she was in an identified state and indicated the resident did not display the identified responsive behaviours towards them until he/she was put in an identified transfer equipment. Both PCAs indicated it would not have been unusual for the resident to exhibit responsive behaviours during care. They indicated they do not know how resident #022 injured the identified part of his/her body.

Interview with PSW #122 indicated he/she does not know how resident #022 sustained injury to the identified part of his/her body but revealed the resident has responsive behaviours and will exhibit responsive behaviours during care. The PSW revealed as well that resident #022 has display an identified responsive behaviour that may of contributed to how the resident sustained the injury and stated he/she had witnessed the identified behaviour.

Interview with RPN #114 stated resident #022 frequently displayed responsive behaviours with staff during care and his/her plan of care identified intervention for staff to manage his/her behaviours. He/she indicated if this intervention does not work, the registered staff is to be called. The RPN indicated he/she was not notified until after the care was provided by PCA #113 who informed him/her that resident #022 had responsive behaviours during care.

The home failed to provide the care to resident #022 as specified in the plan of care.

2. Record review identified that resident #001 returned to the home from the hospital on an identified date. The RD assessed the resident on an identified date.

The RD assessment identified the resident at high nutritional risk related to several medical diagnoses and decline in health condition. The assessment revealed the resident's SDM reported resident #001 likes to drink two identified fluid types.

Resident #001 plan of care related to a risk of fluid deficit directed staff to offer the resident the identified fluid types he/she preferred and to provide an identified fluid type in addition to standard fluids, to promote hydration.

Observations were conducted of meals and fluids served/offered to resident #001on identified dates and noted the resident was not provided the interventions as stated in

his/her plan of care as mentioned above.

Menu review and interview with PCA #128 revealed that they do not have the identified fluid type available in the home and the plan of care related to this fluid preference was not followed.

Interview with RD confirmed that he/she was unaware if the home served an identified fluid type. Further interview revealed that resident #001 should be offered an identified fluid types at meals.

The RD confirmed that the plan of care was not followed as additional fluid over the menu standard were not served to resident #001 and a preferred identified fluid type was not available to the resident. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A complaint was submitted to MOHLTC related to improper care of resident # 001 related to an identified medical treatment provided by the registered staff.

A review of resident # 001's clinical records revealed he/she had a medical diagnosis that resulted in a medical condition on an identified date. A review of the physician order record revealed on an identified date the resident was assessed by the Nurse Practitioner (NP) who prescribed resident #001 to obtain an identified diagnostic test, ordered an identified medication and treatment and for the resident's vital signs to be monitored for an identified number of days.

A review of the vital signs record indicated the vital signs were taken on three identified dates and times. Interview with registered staff #106 revealed the practice is when there is an order for the identified medical treatment administration, the order should be entered in the electronic medication administration record (eMAR) to make sure registered staff from all shifts are checking the order, documenting the treatment administration and efficacy.

A review of the eMAR from an identified month, revealed no documentation for the identified medical treatment. A review of the progress notes for the identified date revealed there was no documentation of the efficacy of the medication treatment and action taken.

Interview with SOC #104 revealed all orders should be entered in the eMAR and the efficacy of the treatment be documented in the progress notes. Interview with SOC #109 indicated the staff should have contacted the physician or NP after three days of monitoring the resident according to the NP order from an identified date. The SOC further indicated that according to the clinical records no referral for re-assessment was done, nor the medication treatment administration assessed when the resident had an identified change in condition.

The licensee failed to provide the care as specified in the resident's plan of care.

The scope of this noncompliance is isolated to resident #001. The severity of the non-compliance and the severity of the harm and risk of further harm is potential.
The licensee failed to ensure that the care set out in the plan of care had been provided to the resident. [s. 6. (7)]

4. The licensee has 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.

Review of a complaint to the MOHLTC reported alleged that the home did not identify a skin integrity impairment to an identified area of the resident's body. The inspector completed a review of the resident's clinical records and conducted staff interviews and was not able to verify the above mentioned concern.

However, during a review of resident #001's progress notes between an identified period in 2016, documentation indicated resident returned from the hospital on an identified date and identified the resident with a skin integrity impairment to identified part of his/her body.

Record review of two identified assessment records of resident #001 identified skin integrity impairment to identified areas of his/her body.

Review of resident #001's written plan of care on an identified date did not indicate any interventions to manage resident #001's identified skin integrity impairment as mentioned above and the resident's plan of care had not updated to reflect his/her change in skin status.

Interviews with PSW #110 and RPN #103 indicated they were aware that resident #001 was at risk for skin integrity impairment related to a medical condition but was not aware resident #001 had any skin integrity impairment as mentioned above.

Interview with RPN #106 revealed resident #001 was at risk for skin impairment but was not able to recall the above skin integrity impairment as mentioned above. The RPN stated when a resident has been identified with a skin integrity impairment, interventions would be initiated to monitor and manage the skin integrity impairment, and that the plan of care would have be revised and updated.

Interview with SOC #104 indicated it is the home's expectation that the plan of care be revised and updated when there has been a change in the resident's skin status.

The home does have a compliance history under the LTCHA, 2007,.c.8,s. 6 (7). A Voluntary Plan of Correction (VPC) was issued in report #2016_301561_0007, on March 22, 2016, and a Written Notification (WN) issued on January 05, 2016 in report #2016_343585_0001. [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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the registered dietitian who is a member of the staff of the home assesses the resident's hydration status, and any risks related to hydration.

Two complaints were received by the Ministry of Health and Long-Term Care (MOH), related to resident #001.

Interview with RD identified that each resident is offered a minimum standard of daily fluids and includes a number of specific fluids at breakfast, lunch, and dinner.

Observations of identified meals and fluids served and offered to resident #001 were completed.

Staff interviews with PSW #110, #128 and #129 revealed that resident #001 is not served the identified fluids as a SDM request, and is served an identified fluid which the resident dislikes.

Staff identified that a small glass consumed would be recorded as "1" or 125ml and large glass as a "2" or 250mls. An interview with the SOC #104 confirmed that staff do not fill glasses of an identified fluids consistency to the top of the glass and are filled to a ribbed marking.

Interview with DDS confirmed that the small cup filled to the top would be 120mls but filled to the ribbed line, as observed, would be 100ml. The DDS further confirmed when staff fill the large cup to the top it would be 225ml but filled to the ribbed line it would be 150mls.

The SOC confirmed documentation of fluid intake would be overestimated when glasses are not filled to the appropriate standard.

Interview with the RD revealed he/she was unaware that resident #001 was not served an identified fluid type at meals; disliked an identified fluid consistency; glasses sizes served were not standardized according to the menu and that staff were not filling the glasses to the appropriate level of one centimeter from the top.

The RD failed to assess hydration risks to resident #001.

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 the registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of resident #001’s clinical records indicated on an identified date and time the resident had an unwitnessed fall and sustained an identified skin integrity impairment to an identified area of his/her body an was transferred to hospital for further assessment. A review of the post fall assessment did not indicate if the resident had on appropriate foot and dress ware. When registered staff #103 was interviewed regarding the above mentioned fall, he/she confirmed that the resident did have proper footwear on at the time of the fall, however, he/she did not document.

On an identified date and time, the resident had a fall and sustained injury to an identified area of his/her body and was transported to the hospital for further assessment.

Review of the written plan of care revealed on an identified date the resident’s identified

family member had removed all inappropriate footwear and specific type of clothing identified as inappropriate for the resident to wear in effort to prevent potential falls. Staff to use the appropriate footwear and proper type of clothing at all times when dressing resident #001. The bed was to positioned to allow the resident easy access to exit and enter safely. The resident was to be checked hourly for safety.

There was no documentation found in the clinical record if the resident had proper footwear or clothes. Interview with PSW #110 revealed the resident had an identified footwear at some point last year but the family collected them. Interview with RPN # 103 revealed the resident did have the identified clothing type and identified footwear at some point last year. The identified clothing type were placed at the end of the closet and staff were using them only when he/she did not have clean clothes in his/her closet. There was no documentation in the clinical record if an assessment was done for unsafe footwear or identified clothing type that were placing the resident at risk for falls. RPN #103 confirmed it was not known for how long the resident had the identified footwear and specific clothing type because it was not documented.

A post fall assessment of resident #001 revealed on an identified date and time the resident was found by staff in an identified position and area of his/her room. The resident was dressed in street clothing and footwear.

A post fall assessment of resident # 001 revealed on an identified date and time the resident was found in an identified position and area of his/her room. According to the progress notes on an identified date, the resident stayed in his/her room because he/she was tired. On an identified date and time the resident was found by staff in an identified position and area of his/her room.

The records indicated that if the resident is falling during a particular time the identified care routine should be assessed and if the resident is falling at a particular time for example, the staff should assist the resident with the identified care half an hour earlier.

A review of the Falls Prevention and Management Program policy, revised on an identified date revealed strategies to consider in reducing and mitigating the risk of falls and included various fall prevention equipments, devices, and care strategies.

A review of resident #001's written plan of care revealed the resident required extensive assistance for an identified care by one staff. The resident will at times require total assist when there is a change in his/her need. Staff to assist with the identified care

during scheduled times throughout the day and evening, and night and when required. Staff to remain with resident #001 during care. The section for the identified focus indicated to see the identified schedule under another focus and had been revised on an identified date.

On an identified date and time the resident was found in an identified position and area in the home. According to the PT assessment the resident is using a mobility device. Interview with PSW #110 revealed the resident did try to stand up. The resident did not have an identified device on when they were seated. Observation on an identified date and time revealed the resident was sitting in the identified room in a chair. Interview with RPN #103 revealed resident #001 is at high risk for falls and he/she did not have an identified device, and staff were checking on him/her when they are passing by the identified room.

Interview with RPN #103 revealed the strategy to prevent falls such as application of devices is initiated if the PT would recommend the intervention or eventually if it is urgent the nurse will get one from the nursing clerk and apply it on the resident.

Interview with SOC #109 revealed the expectation is if a resident is at high risk for falls the registered staff to initiate identified devices that can be provided by the nursing clerk and it is available in the home. She further indicated that the written plan of care should be more precise in regards to an identified care routine, and other interventions that are recommended in the policy for prevention of falls should be trialed if they will be effective with the residents at high risk for falls and after discussion with SDM implemented in practice. [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 with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations

Record review of a Family Council (FC) meeting minutes identified two questions/concerns. The length of time residents must wait for staff to respond to their call bells and what the current staffing ratio is at the home during the night shift per unit.

Review of the minutes and records provided failed to identify evidence of a written response to the concerns identified.

An interview with a member of the FC, present on an identified date revealed that responses to concerns or recommendations are sometimes provided verbally but not in written form.

An interview with the home’s SW, assistant and liaison between the FC and the home, confirmed that a written response had not been provided to FC related to the concern expressed at an identified meeting.

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 licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #6: 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. 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 was complied with.

Review of a complaint dated on an identified date reported allegations of improper care/transfer of resident #022 resulting in an identified medical condition of unknown cause.

Review of the home’s policy entitled, “Falls Prevention and Management Program, Region of Peel Long Term Care Centres”, indicated registered staff are to notify the SDM of the fall.

Review of resident #022's progress notes dated on an identified date and time revealed it was reported by PCA #112 that when he/she arrived on the unit at an identified time he/she witnessed resident #022 in an identified area and position.

Interview with RPN #114 indicated when a resident falls, the home's practice is to notify the SDM of the incident and stated he/she did not call the SDM of resident #022's fall.

Interviews with RN # 111, RN #115, RPN #103, RPN #106, and SOC #109 indicated when a resident falls, the registered staff are responsible to notify the SDM of the fall.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to shall ensure that when a resident has fallen, the resident is

assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of a complaint reported allegations of improper care/transfer of resident #022 resulting in an identified medical condition of unknown cause.

Review of the home's policy entitled, "Falls Prevention and Management Program, Region of Peel Long Term Care Centres", indicated registered staff are to conduct a post fall a post fall huddle, to include a post fall assessment, the Morse Falls Risk Assessment and Initial Post-Fall Assessment in the progress notes with the Risk Management Report in the electronic health record system.

Review of resident #022's written plan of care indicated the resident is at risk for falls characterized by history of falls/injury, related to several multiple risk factors.

Review of resident #022 progress notes at an identified date and time, indicated the resident was found in an identified area and position in his/her room by PCA #112 at the beginning of his/her shift and was not witnessed by staff.

Review of resident #022's PCC assessments did not indicate that an initial post fall assessment was completed for the resident.

Interview with PCA #112 indicated when he/she arrived on the unit on the above mentioned, he/she was informed by PCA #118 that resident #022 had fallen on an identified shift and that he/she assisted PCA #118 to put the resident back to bed. PCA #112 stated he/she then reported the incident to RPN #114 after the morning report was completed.

The inspector contacted PCA #118 twice but was not successful.

Interview with RPN #114 indicated PCA #112 reported to him/her that resident #022 was found in an identified position in their room. He/she stated that this incident would be considered an un-witnessed fall and would require an initial post fall assessment. The RPN stated he/she did not complete an initial post fall assessment for resident #022 because he/she forgot to complete the assessment on that day.

Interview with SOC #109 indicated it is the home's expectation that the registered staff

complete an initial post fall assessment after a resident has fallen and confirmed this had not been done for resident #022. [s. 49. (2)]

WN #8: 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During the Abaqis stage one assessments of the home's Resident Quality Inspection (RQI), resident #021 triggered for a worsening skin integrity impairment according to the

previous assessment on an identified date, to the most recent assessment on an identified date.

Rreview of resident #021's progress notes on an identified date, indicated the resident had verbalized discomfort to an identified area of their body and was assessed to have altered skin integrity related to possibly prolonged sitting. A treatment was applied to the area.

Review of resident #021's Point Click Care (PCC) assessments did not indicate that a skin assessment was completed.

Interview with PSW #117 and #124 revealed they are aware that resident #021 is at risk for skin breakdown and has ongoing issues with an identified skin impairment to identified areas of his/her body that come and go.

Interviews with RN #121 indicated he/she assessed resident #021 on an identified date, to have skin impairment to an identified area of his/her body on an identified date but did not do a skin assessment because the resident has an ongoing issue with skin impairment to the identified areas of his/her body and it come and go and was monitored. The RN stated if the identified skin impairment had persisted, he/she would have initiated a skin assessment.

Interviews with RN #111, RPN #114, RPN #100, and RPN #106 indicated an initial skin assessment must be completed when a resident has been identified with an impaired skin integrity such as any skin impairment as mentioned above.

Interview with SOC #109 indicated it is the home's expectation for the registered staff to initiate a skin assessment when a resident has been identified with a skin integrity impairment.

2. The licensee has 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.

During the home's RQI inspection, noncompliance was issued under the Skin and Wound Inspection Protocol (IP). The resident's sample size was expanded as a result of the noncompliance to resident #022.

Review of resident #022's plan of care indicated the resident has impaired skin integrity and was assessed on an identified date. The plan of care directed staff to monitor for discomfort and complete a weekly skin assessment.

Review of resident's #022's progress notes on identified date indicated the resident received treatment related to altered skin integrity and an identified treatment was applied.

Review of resident #022's PCC assessments indicated over a five week period three of the required five assessments were completed, two were not.

Interviews with #RPN 121, RPN #114, and RPN #100 revealed that registered staff are responsible to monitor and complete a weekly skin assessment located in the PCC for resident's identified with a skin integrity impairment.

Interview with SOC #109 confirmed that there was no weekly skin assessment completed for resident #022 for two identified dates.

3. The licensee has failed to ensure that the resident who is dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

A complaint was received by the MOHLTC related to resident #001, who was dependent on staff for repositioning, was not repositioned every two hours on an identified date.

Complaint #1: Log # #000162-17 identified that for five hours on an identified date in January 2017, no one from the home came into resident #001’s room to repositioned resident all day or to provide any care.

Record review identified that a family member was visiting resident #001 the afternoon of an identified date. The progress notes further revealed that resident #001 remained in bed the day and afternoon shift that day.

Staff interview with PCA #128, #110, and #129 identified that in January 2017 resident #001 had returned from the hospital and was dependent on staff for repositioning. All staff confirmed that repositioning was required every two hours.

Record review of the resident's plan of care failed to identify a focus of repositioning on an identified date. Further record review identified a Task intervention Turned and Repositioned every two hours. This task was initiated and signed by staff starting at 2000 hrs 15 days later.

Interview with SOC #104 revealed that staff would be expected to have turned and repositioned resident #001 every two hours on an identified date, and document. The SOC confirmed there was no evidence that resident #001 was turned and repositioned every two hours the afternoon of an identified date.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Record review and observations identified resident #001 as requiring total staff dependence for eating and drinking.

On an identified date and time, the inspector observed a nourishment pass. At an identified time, resident #001 was served and fed an identified nourishment by PSW #137. A beverage was not offered . Interview with PCA #137 confirmed the resident was not offered a drink during the identified nourishment pass.

2. The licensee failed to ensure the planned menu items are offered and available at each meal and snack.

A review of an identified home snack menu identified a variety of beverages including several identified fluid types.

Interview with the Dietary Services Supervisor identified that residents requiring thickened beverages follow the same menu and dietary staff are responsible for preparing the thickened drinks in advance.

On an identified date, a nourishment pass was observed. The menu stated an identified fluid type. An identified fluid type was not available on the cart. Three identified prepared thickened drinks were available.

Interview with PSW #128 revealed that the identified fluid type thickened was not provided and for the past 10 years there has been only identified fluid types available. PSW #128 stated the menu is not followed and there is a lack of variety of flavours for those residents on thickened fluids.

On an identified date, a nourishment menu identified a fluid type as the beverage choice. The DDS and inspector confirmed with Dietary Aide #130 that a thickened fluid type blend drink was not prepared and three identified thickened drinks were prepared and available.

The DDS confirmed that the planned menu items were not offered.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Two complaints were received by the MOHLTC related to an identified home area with lingering odours, especially during identified times.

The following observations were made by inspector #110 on the reported identified times and noted the identified odours were present in several identified areas of the home.

FA #142 confirmed the presence of an identified odour in the hallway between the identified areas as observed by the inspector and also in an identified resident room with inspector on an identified date.

PCA #110 and #129 confirmed an odour and identified an equipment used for a resident the possible source of the odour.

An interview with the FA #140, a housekeeper, revealed that unit staff verbally communicate if they identify lingering odours and that he/she had not been made aware of a lingering odour in the identified areas of the home. FA #140 was unaware of an odour mitigation policy for lingering offensive odours.

Record review of an identified home's policy and procedure manual failed to identify an odour mitigation policy for lingering offensive odours.

An interview with the ESM revealed he/she was unaware of the persistent lingering odour in a particular room and hallway and confirmed the absence of an odour mitigation policy to manage lingering offensive odours.

Issued on this 30th day of June, 2017

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) : JANET GROUX (606), DIANE BROWN (110), SLAVICA VUCKO (210)

Inspection No. / No de l'inspection : 2017_642606_0008

Log No. / Registre no: 008169-17

Type of Inspection / Genre d'inspection: Other

Report Date(s) / Date(s) du Rapport : Jun 2, 2017

Licensee / Titulaire de permis : THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

LTC Home / Foyer de SLD : MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jessica Altenor

To THE REGIONAL MUNICIPALITY OF PEEL, 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. 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;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(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).

Order / Ordre :

The licensee failed to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks to nutrition and hydration.

1. Educate all staff on the minimum standard of daily fluid to be offered to residents at meals and snacks and what action should be taken when the standard is not accepted.
2. Educate all staff on the serving volume of each daily fluid as part of the menu standard and the accurate recording of fluids consumed.
3. Clarify policy on the process of creating and entering a fluid alert to be generated in the HER. Educate all registered staff, including food service management and the RD on the process.
4. Educate all registered staff on the Hydration program including when to assess and document for signs and symptoms of dehydration and when to refer to the RD.
5. Review the process of assessing the implementing the Hydration program including strategies to promote optimal fluid intake.
6. Educate all registered staff on the process for monitoring and documenting for signs and symptoms of dehydration.
7. Conduct monthly audits for one year to ensure the system of fluid monitoring and evaluation is in place.

Grounds / Motifs :

1. The licensee failed to ensure the hydration program includes to monitor and evaluate the food and fluid intake of residents with identified risks to nutrition and hydration.

Record review of resident #004 current plan of care identified the resident at risk for fluid deficit related to identified medical conditions. The plan of care directed staff to provide fluids as per menu plan and encourage an identified minimum amount of fluids to meet minimum fluid needs and to monitor resident for signs of fluid deficit.

Interview with RPN #132 revealed that the POC generates an alert when the resident consumes less than half and that he/she refers to the RD when a residents intake is poor.

Record review of an identified home's report on an identified time period revealed no days where resident meet his/her minimum fluid goal of an identified amount of fluids.

Review of progress notes between an identified time period revealed no clinical triggers, POC alerts, for decreased fluids.

Record review identified resident was transferred to the hospital and returned to the home on an identified date with an identified discharge diagnosis including an identified fluid deficit.

Interview with SOC #104 confirmed that resident's intake reported on an identified home's report was below his/her estimated servings and that the POC did not trigger an alert for decreased fluids as expected.

Interview with the RD revealed the wrong trigger was set up in POC as resident #004's fluid requirement and therefore did not alert at the correct identified amount. The RD confirmed that resident #004's fluid intake was not evaluated. (110)

2. Record review of resident #003's current plan of care identified the resident at risk for fluid deficit related to a number of health and medical conditions. The plan of care directed staff to provide an identified amount of fluids at each nourishment and encourage to drink an identified amount of fluids to meet minimum fluid requirement and to monitor for signs of fluid deficit and follow-up with the MD/RD as needed.

Interview with RPN #132 revealed that the POC generates an alert when the resident consumes less than half and that he/she refers to the RD when a residents intake is poor.

Record review of an identified home's report for an identified time period revealed on an identified date, when the resident met his recommended fluid intake and that all other days residents intake was below an identified servings of fluid.

Review of progress notes between an identified time period revealed no clinical triggers, POC alerts, for decreased fluids.

Interview with the SOC #104 confirmed that resident's intake reported on an identified home's report was below his/her estimated identified amount of servings and that the POC did not trigger an alert for decreased fluids as

expected.

Interview with the RD revealed there was no trigger set up for resident #003 in PCC and confirmed that fluid intake was not being monitored. [s. 68. (2) (d)]

(110)

3. The licensee failed to ensure the hydration program includes to monitor and evaluate the food and fluid intake of residents with identified risks to nutrition and hydration.

Two complaints were received by the Ministry of Health and Long-Term Care (MOHLTC), related to resident #001.

Record review of resident's plan of care during an identified time in 2016, identified resident #001 at risk for fluid output exceeding intake characterized by a fluid deficit related to a number of identified factors. The plan of care directed staff to encourage a fluid consumption of an identified amount per day to meet minimum hydration needs and for registered staff to monitor for signs of fluid deficit and inform the RD, MD/NP if signs/symptoms were noted.

Record review identified that the resident was assessed, by the NP, upon family request. The assessment plan included an order for an identified medical intervention to rehydrate and lab work. On an identified date, the lab work revealed critical values and the resident was transferred to the hospital.

A review of the identified hospital's consultation report on an identified date revealed that resident #001 was admitted with identified medical conditions.

Staff interviews with PCA #129, #128 and #110 identified that resident #001 was a poor drinker. Interviews further revealed that fluid monitoring was completed by PCA's entering the number of servings of fluid the resident consumed into the Point of Care (POC) for each meal and snack plus any extra fluid was also identified. Staff revealed that Point Click Care (PCC) triggers an alert when the resident's fluid intake was below their fluid requirement for three consecutive

days.

Record review of the progress notes between two identified dates, indicated five alerts related to decreased fluid intake for resident #001.

An identified home's referral form directed registered staff to refer to the RD when a resident was identified with a decreased fluid intake as per intake records and/or risk of dehydration.

The home's Dietary Services, Nutrition and Hydration Program stated the following:
The RD will determine fluid needs and fluid target levels following an assessment. An alert will be generated in the health electronic record (HER) when the resident consumes less than the target fluid intake for three consecutive days. Alerts are monitored by the RN/RPN with appropriate follow up and referrals as needed.

Interview with RPN #103 revealed that the POC generated an alert when the resident consumed less than the recommended intake for three days and otherwise he/she does not monitor the intake records. RPN #103 identified that the RD establishes the recommended fluid amount for the resident and a referral to the RD when they receive the prompt. Staff interviews and record reviews identified that a referral was not sent to the RD for fluid evaluation for the above noted alerts.

Record review of an identified home's report between two identified dates indicated 12 additional periods, of three consecutive days, whereby the resident did not meet his/her daily fluid requirement that did not trigger a POC alert.

Interview with RPN #103, RD and SOC #104 confirmed that a referral should have been sent to the RD as part of monitoring and evaluating the resident's fluid intake. They further confirmed the additional periods of three consecutive days whereby the system did not prompt an alert of poor fluid intake, for the purposes of fluid monitoring and evaluation. [s. 68. (2) (d)]
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee shall:
1. Within one week of receipt of this order review resident #001's plan of care with all direct care staff responsible for the resident's care to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
2. Develop and implement a quality improvement process to ensure that all resident #001 receives the care as specified in his/her plan of care.
3. Document all required steps in 1-2 noted above.

The licensee shall prepare and submit a plan that includes tasks 1-2 and the person(s) responsible for completing the tasks. The plan is to be submitted to Slavica.vucko@ontario.ca by June 16, 2017, and implemented by August 31, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A complaint was submitted to MOHLTC related to improper care of resident # 001 related to an identified medical treatment provided by the registered staff.

A review of resident # 001's clinical records revealed he/she had a medical diagnosis that resulted in a medical condition on an identified date. A review of the physician order record revealed on an identified date the resident was

assessed by the Nurse Practitioner (NP) who prescribed resident #001 to obtain an identified diagnostic test, ordered an identified medication and treatment and for the resident's vital signs to be monitored for an identified number of days.

A review of the vital signs record indicated the vital signs were taken on three identified dates and times. Interview with registered staff #106 revealed the practice is when there is an order for the identified medical treatment administration, the order should be entered in the electronic medication administration record (eMAR) to make sure registered staff from all shifts are checking the order, documenting the treatment administration and efficacy.

A review of the eMAR from an identified month, revealed no documentation for the identified medical treatment. A review of the progress notes for the identified date revealed there was no documentation of the efficacy of the medication treatment and action taken.

Interview with SOC #104 revealed all orders should be entered in the eMAR and the efficacy of the treatment be documented in the progress notes. Interview with SOC #109 indicated the staff should have contacted the physician or NP after three days of monitoring the resident according to the NP order from an identified date. The SOC further indicated that according to the clinical records no referral for re-assessment was done, nor the medication treatment administration assessed when the resident had an identified change in condition.

The licensee failed to provide the care as specified in the resident's plan of care.

The scope of this noncompliance is isolated to resident #001. The severity of the non-compliance and the severity of the harm and risk of further harm is potential.

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

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

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

Issued on this 2nd day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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