Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2017	2017_449619_0007	006380-17	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

GRACE MANOR
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

SAMANTHA DIPIERO (619), BERNADETTE SUSNIK (120), KELLY HAYES (583), NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 24, 27, 28, 29 30, 31, 2017, and April 4, 5, 6, 7, 10, 11, 12, 2017

During this inspection, the inspections listed below were conducted concurrently:
Critical Incident Inspections
025782-16 - related to responsive behaviours
028585-16 - related to abuse
030127-16 - related to falls prevention
000587-17 - related to neglect
000859-17 - related to abuse
004471-17 - related to abuse
033777-16 - related to falls prevention
000861-17 - related to personal support services
033207-16 - related to abuse
030262-16 - related to abuse

Follow Up Inspection
035199-16 - related to bed rails

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Assistant Director of Care (ADOC), Physiotherpist (PT), Registered Dietitian (RD),Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aides, Activation staff, Resident Assessment Instrument (RAI) Co-ordinator, Environmental Services Supervisor (ESS), Occupational Therapist (OT), residents and families.

During the course of the inspection the inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_539120_0070	120

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. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee received

from the Minister under section 90 of the Act.

During stage one of the Resident Quality Inspection (RQI), in an interview, resident #050 stated that the home's staff do not provide foot care services and that they paid a professional foot care nurse to provide foot care care every six weeks. A review of the resident's clinical record did not indicate that the resident had a foot care assessment completed by the home and did not indicate that the resident had a need for advanced foot care services.

In a second interview with the SDM for resident #008, they stated that they paid for professional foot care services every six weeks. The SDM indicated that they were not told that the home offered basic foot care services and that they were required to pay for professional foot care services or provide the care themselves. The SDM confirmed that resident #008 did not have any chronic or acute health issues that would prohibit them from receiving basic foot care from care staff in the home. This information was confirmed by a review of the resident's clinical record.

In an interview, registered staff #126 stated that few residents' foot care was provided by staff and that many of the residents elected to have professional foot care services. Registered staff #126 further indicated that the home's staff do not complete a foot care assessment on residents prior to being referred to a professional foot care service provider on admission. Registered staff #126 stated that should residents require basic foot care services, that the home's staff should provide that service.

A review of the home's policy titled, "LTC Care Staff Guidebook", last revised March 2017, stated, “Residents who do not arrange for foot care services, PSW will provide basic foot care. For diabetic residents; registered staff will provide foot care as required.”

LTCH Inspector determined that the basic foot care service policy to be provided by the home does not include basic trimming and filing of resident toe nails, and does not differentiate the requirements between basic and advanced foot care needs.

A review of the “Purchased Services Agreement”, last revised in September 2016, stated, “Certain services for residents of Ontario LTC facilities are subject to a charge above the amount of the monthly accommodation rate. They are called “Unfunded Services”. The charges are subject to change and current rates are available upon request.” Further review of this document, which was confirmed by the DRC as part of the admissions package for all residents newly admitted to the home, indicated that this

document does not define basic or advanced foot care services, and only offers a selection between "yes" or "no" for "Professional Foot Care Services – cost not covered by OHIP for the provision of professional foot care." Interview with DRC confirmed that residents and SDM's are not educated regarding the actual needs related to advanced foot care services.

Following the "Purchased Services Agreement" in the admissions package a "Consent to Treatment – Foot care", last updated in September 2016, stated, "I hereby consent to treatments prescribed as indicated on the treatment plan for foot care". The DRC confirmed this document does not state the reasons why advanced foot care services may be required, nor does it state the cost of the service.

A request was made for the home to provide an updated copy of the total number of residents who gave consent for the contracted service provider to cut their toenails. A review of the document titled, "User Defined Information – Podiatry Notes" provided by the home indicated that 77 of 116 residents gave consent for and receive contracted service for advanced foot care services provided by an external foot care services provider.

The DRC confirmed that the home does not assess residents on admission to determine what type of foot care services are required for each individual resident. The DRC further stated that on admission, residents were offered foot care service through the contracted provider to provide care every four to six weeks and that if new residents wanted the service, they were expected to sign a consent form that did not list the price of the service. The DRC confirmed that not all of the residents who provided consent had chronic or acute conditions that required them to have advanced foot care services, and further confirmed that residents who did not have chronic or acute conditions that required them to have advanced foot care services should not be expected to pay for the care, and should have their toe nails cut by the registered staff.

In an interview with the contracted service provider, the representative confirmed that residents are billed monthly for professional foot care service from their company to provide "advanced", not "basic", foot care to consenting residents every four to six weeks.

The licensee referred residents to professional foot care services for basic toenail care that the home was required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.

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. 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 :

The licensee failed to protect the resident from abuse and neglect by anyone.

On an identified date in January 2017, prior to a meal service resident #043 needed extensive assistance from two staff for transfers via a mechanical lift, advised PSW #218 that they experienced an episode of bowel incontinence and required assistance to be cleaned up. Interview with resident #043 indicated that they were denied their request and instead, were brought to the meal service which lasted approximately one hour, after which they were taken to their room and cleaned. Interview with PSW #218 indicated that due to the need for staff to be in the dining room during the meal service, and the resident's requirement for two staff, they were unable to assist the resident. In an interview PSW #218 confirmed that the resident had an episode of incontinence and that the resident's request to be changed prior to the meal service was denied. A review of the home's policy titled. "Zero Tolerance of Resident Abuse & Neglect", last revised December 2016, stated, "Holland Christian Homes promotes and maintains a Zero Tolerance of abuse and neglect of residents for any type of abuse of a resident by family, substitute decision maker, management, staff…". Interview with ADOC confirmed that the inactions to provide care and assistance to resident #043 by PSW #218 and RPN #108 constituted neglect.

B) Resident #044 had a history of cognitive impairment, and a history of responsive behaviours. On an identified date in September 2016, resident #044 was abused by

PSW #204; this incident was witnessed by the resident's Substitute Decision Maker (SDM). A review of the home's policy titled, "Zero Tolerance of Resident Abuse & Neglect", last revised December 2016, stated, "Holland Christian Homes promotes and maintains a Zero Tolerance of abuse and neglect of residents for any type of abuse of a resident by family, substitute decision maker, management, staff…". Interview with ADOC confirmed that PSW #204 abused resident #044.

C) In an interview on an identified date in April 2017, resident #047 stated that when they rang for assistance PSW #187 made inappropriate comments to them. The resident further stated the same PSW was rough when providing their care. A review of a document titled "Family/Resident/Staff Concern or feedback form", dated in February 2017, indicated resident #041's family member expressed a concern to the DRC where the resident complained that PSW #187 was rough during their care, and made inappropriate comments to them which made them upset. A review of the home's policy, titled "Resident Abuse and Neglect", revised in June 2015, indicated the home maintained a zero tolerance approach towards abuse or neglect of residents. In an interview in April 2017, the ADOC confirmed that as a result of the home's investigation, PSW #187 emotionally abused resident #047.

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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 :

The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

1. A review of resident #020's March 2017, quarterly review assessment identified they were assessed to require extensive assistance from one staff for toileting and perineal care. The physiotherapy assessment completed on an identified date in March 2017, identified that resident #020 required supervision and assistance with toileting for safety. A review of the progress notes identified resident #020 had a fall on an identified date in February 2017, when they attempted to toilet themselves independently. A review of the written plan of care indicated that Resident #020's toileting care plan goal was for the resident to be able to toilet themselves independently and the toileting intervention identified the resident sometimes toileted themselves. In an interview with registered staff #119 and PSW #201, it was shared that resident #020 was able to toilet themselves and that staff did not provide assistance, they just reminded the resident to use their mobility device. In an interview with the ADOC in April 2017, it was confirmed that resident #020's toileting care plan did not provide direct care staff with clear direction related to what level of assistance staff were to provide the resident.

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

A) On an identified date in January 2016, resident #008 returned from hospital with orders for a medical procedure twice daily. On an identified date in January 2017, the home’s physician discontinued the order for the medical procedure as the resident’s issue had resolved and the resident no longer required the procedure. On review of the resident’s Treatment Administration Record (TAR) and Medication Administration Record (MAR) the resident received a medical procedure on an identified date in January 2017, after the order for the medical procedure was discontinued. A review of the progress notes, and interview with RPN #138 indicated that the evening shift registered staff on an identified date in January 2017, identified as RPN #143 did not enter the physician’s order for discontinuation of the medical procedure, as a result the order was still active on the resident’s electronic MAR (E-MAR), and care was provided. Interview with ADOC confirmed that the registered staff did not provide care to the resident as specified in the plan of care.

B) Resident #008 returned from hospital on an identified date in November 2016. A review of the resident’s clinical record indicated that the resident had an intervention implemented from an identified date in November 2016, until an identified date in January 2017. A review of the progress notes indicated that the home’s physician discontinued the resident’s intervention on an identified date in January 2017. An interview with resident #008 indicated that intervention was implemented for “too long”; a further review of the progress notes indicated that the resident's intervention continued to be implemented until a second identified date in January 2017, although it was previously discontinued. Interview with RPN #118 indicated that communication between registered staff did not take place and that as a result the resident continued to have the intervention implemented for a period of six (6) days. Interview with ADOC confirmed that the registered staff did not provide care as set out in the plan of care for resident #008.

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

A) Resident #004 was admitted in October 2016, and required ongoing treatment for chronic pain management. A review of the resident’s health record indicated that on two

occasions, in November 2016, and March 2017, the resident's treatment was noted as missing. A review of the resident's written plan of care, last revised November 2016, indicated that the resident had a history of removing the treatment. Interview with RPN #130 indicated that when a resident has been noted to have removed the treatment and that staff can alter the treatment to one that is inaccessible to the resident. Interview with PRN #130 confirmed that resident #004 did not have the mobility required to access certain areas on their body. Interview with ADOC confirmed that the resident's plan of care was not updated to include the use of an application site for the resident's treatment that was not accessible to the resident. The ADOC confirmed that this information was updated in the resident's written plan of care on April 2017.

B) In an interview in April 2017, resident #041 stated they needed assistance at all meals. They stated the staff sometimes assisted, but most of the time did not provide more than set-up assistance resulting in the resident consuming very little of their meals. The resident stated they were once able to feed themselves with minimal assistance, however; their status had declined that required more assistance. A review of resident #041's most recent Minimum Data Set (MDS) assessment, dated in February 2017, indicated the resident required extensive assistance with eating and drinking. A review of the resident's previous MDS assessment, dated in December 2016, indicated the resident needed supervision only with eating and drinking, confirming that their condition had deteriorated. A review of the resident's most recent written plan of care indicated they were able to feed themselves with set up, and staff were to sometimes assist with feeding. In an interview, registered staff #108 stated the resident needed assistance with meals at all times and confirmed the written care plan was not update when the resident's care needs changed.

C) In an interview in April 2017, resident #041 stated they did not have any skin and wound issues however; a corrective instrument was used for protection. A review of the resident's most recent written plan of care indicated the resident had ongoing skin and wound issues. A review of the progress notes on an identified date in February 2017, indicated a specialized nurse during their assessment identified two (2) wounds. A review of the resident's most recent MDS assessment, completed on an identified date in February 2017, indicated they had one or more care problems on an identified area of their body, required care, and had two wounds. A review of the home's policy #NUR-01-101, titled "Skin and wound care program", revised March 2017, indicated registered staff were responsible to maintain a current resident care plan that reflects the current status of the residents' wounds. In an interview on the same day, registered staff #108 stated the resident's wounds as indicated above had healed. In an interview, the DRC

confirmed the corrective instrument was no longer necessary.

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 with s. 6(1)(c) where every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, and with s. 6(7) where the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and with s. 6(10)(b) where 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A) During a review of the employee shift schedule it was identified that the home made a change to the 0700 to 1500 hour scheduled RN shift. In an interview with the secretary that was in charge of scheduling, it was confirmed that in April 2017, the home had moved to a new schedule, related to a restructuring change. It was shared that the Monday to Friday 0700 to 1500 hour scheduled RN shift was eliminated and that the ADOC would replace the RN shift.
On six (6) identified dates in April 2017, the DOC was not present in the home and the ADOC was covering in their absence. On an identified date in April 2017, during the period of DRC's absence, the ADOC had to attend off site meetings for a period of four (4) hours.

In an interview with the Administrator on an identified date in April 2017, it was confirmed that:
i) The ADOC cannot work in the capacity of the RN while working in ADOC role
ii) The ADOC was replacing the DRC for a period of six (6) identified dates in April 2017
iii) The ADOC was off site for education on an identified date in April 2017 for a period of four hours

It was identified that the home was aware of the requirements for 24-hour nursing care but failed to ensure that an RN was on duty and present in the home from 0700 hours to 1500 hours on six identified dates in April 2017.

B) On an identified date in April 2017, Inspector #591 identified that an agency nurse was working the 0700 hours to 1500 hours shift. In an interview with the administrator on an identified date in April 2017, it was confirmed that an agency staff was used but that there was not an emergency per the legislation definition and that the DRC was not available by phone as they were not in the country. It was confirmed that no member of the regular nursing staff who was a registered nurse, was on duty.

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 with s. 8(3) where 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

On an identified date in September 2016, resident #044 was exhibiting responsive behaviours towards staff. A review of the resident’s written plan of care last updated in December 2015, indicated that the resident at times required the use of a mobility device for comfort when unable to ambulate independently. Interview with the resident’s Substitute Decision Maker (SDM) confirmed that they consented to the use of a Personal Assistive Service Device (PASD) but did not consent to the use of a restraint, or a PASD with restraining effects. Interview with day shift PSW #230 indicated that resident #044 was displaying responsive behaviours and that they tilted the mobility device into a reclined position to prevent resident #044 from displaying physically aggressive behaviours towards staff, and prevent them from rising from the mobility device. Interview with day shift RPN #145 indicated that a tilt restraint was placed on the resident to prevent the resident from potentially falling and confirmed that they were aware the resident did not have an order for a tilt restraint.

Interview with evening shift PSW #204 indicated that the resident was reclined in the mobility device and that they did not remove the restraint from the resident. Interview with evening shift RPN #136 confirmed that resident #044 did not have an order for restraining by a physical device and that no assessment for a physical restraint was completed. A review of the resident’s clinical record did not indicate that any order by a physician was made for the purpose of tilting/reclining the resident when seated in the tilt chair.

A review of the home’s policy titled, “Least Restraints – Use and Application”, policy #NC-00-02, last revised March 2017, stated, “Physician or Nurse Practitioner order for a restraint must be obtained in writing which include: 1) Type of physical restraint to be used, 2) reason(s) for the restraint, 3)When the restraint is to be used, and 4) length of time the resident is to be in the restraint.” Interview with ADOC confirmed that resident #044 was physically restrained by staff. The ADOC confirmed that the resident was restrained via a tilting mechanism on their wheelchair for an extended period of time on an identified date in September 2016, without first being assessed for the restraint, consented to by the resident's SDM, and without an order from the home’s physician.

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 with s. 30(1) where every licensee of a long-term care home shall ensure that no resident of the home is 3) Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) In an interview with staff #300 it was shared they were requested to assist in the transfer of resident #061 by another staff member who provided direct nursing care. Staff number #300 confirmed they assisted in the transfer of resident #061 on an identified date in March 2017, who required the use of a lift and assistance from two staff members for transfers. Staff #300 shared they had not received training on use of safe transferring and positioning devices or techniques and were not trained to provide direct care to residents.

B) In an interview with staff #301 it was shared they were requested to assist in the transfer of resident #062 by another staff member who provided direct nursing care. Staff #301 confirmed they assisted in the transfer of resident #062 on an identified date in March 2017, who required that use of lift and assistance from three staff members for transfers. Staff #301 shared they had not received training on use of safe transferring and positioning devices or techniques and were not trained to provide direct care to residents.

C) In an interview with resident #030 who was capable, it was shared that staff #302, assisted in the transfer of the resident from their bed to their mobility device. The resident required the use of a lift and three staff members for safe transfers. The resident was transferred by a registered staff and a PSW, however; a second PSW could not be located to assist with the transfer at the time, therefore, staff #302 was requested to assist them. In an interview with the Administrator on an identified date in April 2017, it was shared that the staff #300, #301, and #302 were not trained to provide direct nursing care. It was confirmed that staff failed to ensure safe transferring techniques were used when assisting residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 36 where every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

On an identified date in September 2016, resident #044 was noted by PSW #230, and RPN #145 as displaying increased responsive behaviours. In an interview, RPN #145 indicated that they did not assess the resident's responsive behaviours and did not make a referral to the Behavioural Support Ontario (BSO) staff for further assessment. RPN #145 further indicated that they did not document the resident's behaviours and did not pursue direction on interventions to reduce the increased behaviours. A review of the home's policy titled, "Behaviour Management Program", last revised March 2017, stated, "The RN/RPN is responsible for completing the risk management and following up with BSO/DOC/ADOC… nursing staff document on a shift by shift basis all resident behaviours… and staff can make a referral online for behavioural support". An interview with the ADOC confirmed that the home's staff did not assess, document, or adequately intervene when the resident was displaying increased responsive behaviours.

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 with r. 53(4) where the licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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 :

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the area of abuse recognition and prevention at times or at intervals provided for in the regulations.

A review of the “Resident Abuse and Neglect by Surge Learning” and the “Prevention of Abuse and Neglect/Abuse Definitions/Abuse Tree” training completion records identified that 93 out of 106 direct care staff completed annual training in 2016. In an interview with the human resource staff it was confirmed that the home had 106 direct care staff in 2016. In an interview with the Administrator on an identified date in April 2017, it was confirmed that 13 staff did not complete annual training in the area of abuse recognition and prevention as directed in the regulations, for a total of 87% direct care staff trained.

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 with s. 76(7) where 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, 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. (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 :

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

In an interview with registered staff #250 on an identified date in April 2017, it was shared that they began administering the 0800 hour medications late after it was identified that the RPN scheduled to replace them did not arrive for the 0700 hour shift. Registered staff #250 was approached by a person of importance to resident #060 because they observed resident #060 to be in pain. A review of the medication administration record identified resident #060 had a daily pain medication order at an identified time. In an interview with registered staff #250 it was confirmed that resident #060's identified pain medication was administered two (2) hours after it was identified the resident’s pain was not controlled. It was observed that registered staff #250 completed the 0800 hour medications for the residents at approximately three (3) hours later. In an interview with the Administrator on an identified date in April 2017, it was confirmed that the licensee failed to ensure that drugs were administered to residents in accordance with the times specified by the physician.

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 with r. 131(2) where the licensee shall 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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A) A review of a document titled “Family/Resident/Staff Concern or feedback form", submitted on an identified date in February 2017, indicated resident #041's family member expressed a concern to the DRC that the resident complained that PSW #187 was rough during their care, and made inappropriate comments to them. The resident stated that the actions of the staff member made them feel upset. A review of the home's records and investigation notes did not include a documented record related to the above mentioned complaint, as per the Long Term Care Homes (LTCH) Act and legislation requirements. In an interview in April 2017, the ADOC confirmed the home did not keep a written record of the complaint of alleged abuse by PSW #187 to resident #047, reported by their family member.

B) On an identified date in November 2016, resident #048's spouse shared with the registered staff #109 that the resident was upset because a staff member had yelled at them. On a second identified date in November 2016, the Social Service Worker received two separate complaints from resident #048's Substitute Decision Maker (SDM) and another family member. An investigation interview was completed by the ADOC with resident #048. In a progress note documented in November 2016, it was documented that the investigation had been completed and the SDM was informed. In an interview with the DRC on an identified date in April 2017, it was confirmed that there were no documented records of the final resolution, no documented records of the responses made to the complainant or resident #048 or a description of any responses made in turn by the complainant or resident.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents’ Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: (3) The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council on an ongoing basis.

In an interview on an identified date in March 2017, resident #030, who was not a member of the Resident's Council, stated they were concerned that care was not being provided to them as a result of the home's budget cuts and changes to staffing. Residents #049 and #050, who were Residents' Council members also, stated that the recent cuts to staffing were affecting their care negatively, and confirmed that the home did not notify the Residents' Council of the organizational changes in any of the meetings. They stated they became aware of the changes from the staff.

In interviews in March and April 2017, the home's Administrator stated that the organization was restructuring the staffing complement and changes to the provision of care were in progress. They further confirmed that this change was communicated by way of a presentation and written letter to the Family Council members prior to the changes taking effect, however; the presentation and changes were not shared with the Residents' Council. The licensee did not ensure changes to care and services provided to the residents was communicated to the Residents' Council.

Issued on this 26th day of May, 2017

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

Original report signed by the inspector.

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) :	SAMANTHA DIPIERO (619), BERNADETTE SUSNIK (120), KELLY HAYES (583), NATASHA JONES (591)
Inspection No. / No de l'inspection :	2017_449619_0007
Log No. / Registre no:	006380-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 12, 2017
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

To HOLLAND CHRISTIAN HOMES INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall do the following:
1. Immediately cease charging residents for basic toenail care.
2. Registered staff in the home will complete a foot care assessment with the use of a clinically appropriate assessment tool on all residents in the home to determine every resident's basic or advanced foot care requirement.
3. Revise the admissions package to include information on the home's obligation to provide basic foot care to all resident's and detail what is included in the provision of basic foot care.
4. Revise the "Foot Care Consent and Authorization" form to include information related to the assessed necessity for advanced foot care by an outside contractor, what care is provided, when it will be provided, total cost of the care per treatment, and any other information deemed necessary.
5. Include details on admission and in the admission package related to basic toenail care, and outline the procedure and any related costs for advanced foot care.
6. Revise the Long-Term Care Guidebook to better define basic and advanced foot care services including roles and responsibilities of care providers including filing and trimming of toe nails .
7. Obtain new written consent using the revised foot care consent form as outlined above, for those resident's requiring advanced foot care services and those residents who choose to retain the external service provider for foot care services
8. For every resident that has paid for the contracted service for basic toenail care prior to the 2017 Resident Quality Inspection, the home shall reimburse total charges paid back dated to August 1, 2016.
9. Notify and explain the reason for the reimbursement of charges for toenail care and include the name of the individual (resident/SDM) to whom this discussion was provided to in documentation in the health record.
10. Obtain signature of receipt of total fees reimbursed to each resident.
11. Obtain new written consent using the approved, revised consent form as outlined above, for those residents assessed as requiring the contracted service provider to provide them with advanced foot care and retain a copy of the consent in the residents health record (former consent forms shall be made null and void).

Grounds / Motifs :

1. 1. Judgement Matrix:
Severity: Minimal harm/Potential for harm
Scope: Widespread

Compliance History: One or more related non-compliances in the last three years

2. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.

During stage one of the Resident Quality Inspection (RQI), in an interview, resident #050 stated that the home's staff do not provide foot care services and that they paid a professional foot care nurse to provide foot care care every six weeks. A review of the resident's clinical record did not indicate that the resident had a foot care assessment completed by the home and did not indicate that the resident had a need for advanced foot care services.

In a second interview with the SDM for resident #008, they stated that they paid for professional foot care services every six weeks. The SDM indicated that they were not told that the home offered basic foot care services and that they were required to pay for professional foot care services or provide the care themselves. The SDM confirmed that resident #008 did not have any chronic or acute health issues that would prohibit them from receiving basic foot care from care staff in the home. This information was confirmed by a review of the resident's clinical record.

In an interview, registered staff #126 stated that few residents' foot care was provided by staff and that many of the residents elected to have professional foot care services. Registered staff #126 further indicated that the home's staff do not complete a foot care assessment on residents prior to being referred to a professional foot care service provider on admission. Registered staff #126 stated that should residents require basic foot care services, that the home's staff should provide that service.

A review of the home's policy titled, "LTC Care Staff Guidebook", last revised March 2017, stated, "Residents who do not arrange for foot care services, PSW will provide basic foot care. For diabetic residents; registered staff will provide foot care as required."

LTCH Inspector determined that the basic foot care service policy to be provided by the home does not include basic trimming and filing of resident toe nails, and

does not differentiate the requirements between basic and advanced foot care needs.

A review of the “Purchased Services Agreement”, last revised in September 2016, stated, “Certain services for residents of Ontario LTC facilities are subject to a charge above the amount of the monthly accommodation rate. They are called “Unfunded Services”. The charges are subject to change and current rates are available upon request.” Further review of this document, which was confirmed by the DRC as part of the admissions package for all residents newly admitted to the home, indicated that this document does not define basic or advanced foot care services, and only offers a selection between “yes” or “no” for “Professional Foot Care Services – cost not covered by OHIP for the provision of professional foot care.” Interview with DRC confirmed that residents and SDM’s are not educated regarding the actual needs related to advanced foot care services.

Following the “Purchased Services Agreement” in the admissions package a “Consent to Treatment – Foot care”, last updated in September 2016, stated, “I hereby consent to treatments prescribed as indicated on the treatment plan for foot care". The DRC confirmed this document does not state the reasons why advanced foot care services may be required, nor does it state the cost of the service.

A request was made for the home to provide an updated copy of the total number of residents who gave consent for the contracted service provider to cut their toenails. A review of the document titled, “User Defined Information – Podiatry Notes” provided by the home indicated that 77 of 116 residents gave consent for and receive contracted service for advanced foot care services provided by an external foot care services provider.

The DRC confirmed that the home does not assess residents on admission to determine what type of foot care services are required for each individual resident. The DRC further stated that on admission, residents were offered foot care service through the contracted provider to provide care every four to six weeks and that if new residents wanted the service, they were expected to sign a consent form that did not list the price of the service. The DRC confirmed that not all of the residents who provided consent had chronic or acute conditions that required them to have advanced foot care services, and further confirmed that residents who did not have chronic or acute conditions that required them to

have advanced foot care services should not be expected to pay for the care, and should have their toe nails cut by the registered staff.

In an interview with the contracted service provider, the representative confirmed that residents are billed monthly for professional foot care service from their company to provide “advanced”, not “basic”, foot care to consenting residents every four to six weeks.

The licensee referred residents to professional foot care services for basic toenail care that the home was required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.
(619)

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

Order / Ordre :

1) Ensure that all residents, including but not limited to resident #043, #044, and #047 are protected from abuse and neglect by anyone.
2) Provide education and training for all direct care provider staff in relation to home's Zero Tolerance of Abuse Policy, ensuring 100% completion of this training.
3) Ensure staff comply with the homes policy in relation to the prevention of abuse and neglect

Grounds / Motifs :

1. 1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isolated
Compliance History: One or more related non-compliances in the last three years

2.The licensee failed to protect the resident from abuse and neglect by anyone.

On an identified date in January 2017, prior to a meal service resident #043 needed extensive assistance from two staff for transfers via a mechanical lift, advised PSW #218 that they experienced an episode of bowel incontinence and required assistance to be cleaned up. Interview with resident #043 indicated that they were denied their request and instead, were brought to the meal service which lasted approximately one hour, after which they were taken to their room and cleaned. Interview with PSW #218 indicated that due to the need for staff to be in the dining room during the meal service, and the resident's requirement for two staff, they were unable to assist the resident. In an interview PSW #218 confirmed that the resident had an episode of incontinence and that

the resident's request to be changed prior to the meal service was denied. A review of the home's policy titled. "Zero Tolerance of Resident Abuse & Neglect", last revised December 2016, stated, "Holland Christian Homes promotes and maintains a Zero Tolerance of abuse and neglect of residents for any type of abuse of a resident by family, substitute decision maker, management, staff…". Interview with ADOC confirmed that the inactions to provide care and assistance to resident #043 by PSW #218 and RPN #108 constituted neglect.

B) Resident #044 had a history of cognitive impairment, and a history of responsive behaviours. On an identified date in September 2016, resident #044 was abused by PSW #204; this incident was witnessed by the resident's Substitute Decision Maker (SDM). A review of the home's policy titled, "Zero Tolerance of Resident Abuse & Neglect", last revised December 2016, stated, "Holland Christian Homes promotes and maintains a Zero Tolerance of abuse and neglect of residents for any type of abuse of a resident by family, substitute decision maker, management, staff…". Interview with ADOC confirmed that PSW #204 abused resident #044.

C) In an interview on an identified date in April 2017, resident #047 stated that when they rang for assistance PSW #187 made inappropriate comments to them. The resident further stated the same PSW was rough when providing their care. A review of a document titled "Family/Resident/Staff Concern or feedback form", dated in February 2017, indicated resident #041's family member expressed a concern to the DRC where the resident complained that PSW #187 was rough during their care, and made inappropriate comments to them which made them upset. A review of the home's policy, titled "Resident Abuse and Neglect", revised in June 2015, indicated the home maintained a zero tolerance approach towards abuse or neglect of residents. In an interview in April 2017, the ADOC confirmed that as a result of the home's investigation, PSW #187 emotionally abused resident #047.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 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 12th day of May, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Samantha Dipiero

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