Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 09, 2017;	2017_620126_0004 (A1)	004643-17, 005481-17, 006193-17	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The submission date for the compliance plan for Orders #001 and #002 have been extended to September 15, 2017 .The compliance due date for Orders # 001 and #002 have been extended to December 1, 2017. These changes have been made as per the request of the licensee.

Issued on this 9 day of August 2017 (A1)

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

Original report signed by the inspector.

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 9, 10, 15, 29, 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 27, July 4, 5, and 6, 2017

This inspection was initially started as a Critical Incident Inspection and a complaint inspection was added as part of this inspection.

During the course of this inspection the following logs were inspected:

Log # 004643-17, 005481-17, 006193-17: Critical Incidents that the home submitted related to allegations of abuse to a resident.

Log # 006301-17: Complaint related to care and services

During the course of the inspection, the inspector(s) spoke with identified resident and their Substitute Decision Maker (SDM), Personal Support Workers (PSW) , Registered Practical Nurses (RPN), Registered Nurse (RN), the Rehabilitation Assistant (equipment), the Physiotherapist, Administrative Assistants, the Pharmacist of the home, two Dietary Aids (DA), the Registered Dietitian (RD), the Food Service Supervisor (FSS), the Program Manager of Personal Care (PMOPC), the Program Managers of Resident Care (PMORC), the home's Acting Administrator, and the Acting Director Long-Term Care Home Branch (ADLTCHB) of the City of Ottawa .

During the course of this inspection, the inspector observed care and services given to the identified resident, reviewed the staff education history reports, reviewed the criminal reference checks, reviewed applicable policies, practices, procedures, investigation notes, other evidences and the health care record of the identified resident.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Hospitalization and Change in Condition

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **1 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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure to position resident #001, in bed, as specified in the plan of care.

Resident #001's plan of care, requires staff to use a specified intervention related to risk for bed entrapment.

During the course of this inspection, Inspector #126 reviewed the evidence related to identified incidents. PSW #117 was observed positioning resident #001 in bed for the night without the intervention as specified in the plan of care. On another identified date, PSW #126 and PSW #127 were observed positioning resident in bed for the night, without the intervention as specified intervention.[s. 6. (7)]

2. The licensee has failed to provide Fortified Mashed Potatoes (FMP), twice daily to resident #001.

Resident #001 was admitted to the home with several diagnoses.

Resident #001's plan of care, indicated that resident was to received fortified mashed potatoes twice a day. On a specific day in May 2016, the Registered Dietitian (RD) completed the quarterly assessment and documented in the progress notes that resident #001 had a gradual weight loss in 6 months. The RD ordered to start FMP, twice a day to supplement intake and support weight maintenance. On a specific day in August 2016, the RD documented in the progress notes that she observed resident #001 during a meal observation to be receiving the FMP at that time.

On a specific day in November 2016, the RD completed the quarterly assessment and documented in the progress notes that resident #001 has had significant weight loss in 3 months and that the weights were stable from September to November. On that same day, the RD documented in the progress notes that she had ordered FMP in May 2016, but when she observed resident #001 during a meal observation at lunch time, she noted that the resident did not receive the FMP. The RD reviewed the "houselist" to ensure resident #001 was on the list to receive the FMP and noted that resident #001 was not on the November 2016 list. On a specific day in November 2016, the RD reordered the FMP twice a day to supplement intake and support weight maintenance.

Interview with the Registered Dietitian (RD), indicated to Inspector #126, that on a specific day in November 2016, she observed the resident at meal time and noted that the FMP was not given. The RD indicated that when she orders any type of supplement for residents, the process is to document the order in the communication book and the information is reviewed by the Food Service Supervisor (FSS), it is then communicated to the kitchen for preparation and it is added to the "houselist". The RD indicated that she did not know how long the

resident did not get the FMP but it was highly unlikely that resident #001 did get the FMP for several days in November 2016 as resident #001 was not on the "houselist" of November 2016.

Interview with the FSS #104, indicated to Inspector #126, that he/she did not know when or why resident #001 was not receiving FMP in November 2016. FSS #104 indicated that the process for dietary orders are to be written in the communication book by the RD. FSS #104 reviewed the communication book and noted that the RD ordered FMP twice, on a specific day in May and November 2016. The FSS indicated that they do not keep the monthly copies of the "houselist" and was unable to identify exactly when resident #001 stopped receiving the FMP.

On a specific day in November 2016, the RD observed that resident #001 not receiving for several days the FMP as specified in the plan of care. [s. 6. (7)] [s. 6. (7)]

3. The licensee has failed to ensure that resident #001 was transferred from his/her wheelchair (w/c) to the bed with the assistance of two persons as specified in the plan of care.

Resident #001’s plan of care, requires staff to use the following intervention related to transfer "requires the assistance of 2 or more persons and that the mechanical lift may be used as resident not able to weight bear".

During a telephone conversation with resident's #001 family member, Inspector #126 was informed that PSW #117 was observed on a specified day to be transferring resident #001 from the wheel chair (w/c) to the bed independently without the assistance of another staff.

During an interview, Registered Nurse (RN) #111 indicated to Inspector #126 that an interview was conducted with PSW #117 who had worked on that specific day. RN #111 asked PSW #117 if assistance was requested from a colleague and PSW #117 said that no assistance was requested to transfer resident #001.

During an interview, PSW #112 indicated to Inspector #126, that she/he worked on that specific day and was working in team with PSW #117. PSW #112 indicated that PSW #117 did not request assistance to transfer resident #001.

During an interview, PSW #116 indicated to Inspector #126, that he/she worked

on that specific day for a short shift. PSW #116 indicated that he/she did not provide assistance to PSW #117 in transferring resident #001 from the w/c to the bed nor was asked to provide assistance.

During an interview, the Acting Director Long Term Care Home Branch (ADLTCHB), indicated to Inspector #126, that with the evidence provided to the Home, the evidence revealed that PSW #117 was transferring resident #001 from the w/c to the bed independently without the assistance of another staff.

A review of the evidence by Inspector #126 related to the identified incident revealed that PSW #117 was transferring resident #001 from the w/c to the bed independently without the assistance of another staff.

The licensee has failed to ensure that resident #001 was transferred by 2 person's transfer as per the plan of care. [s. 6. (7)] [s. 6. (7)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect resident #001 in that PSW #117 did not comply with the home's Abuse Policy # 750.65, revised September 2016.

The licensee's "Abuse Policy" -750.65 last revised September 2016 requires staff under the section:
"Practice:
The Homes are committed to zero tolerance of abuse or neglect to our residents. The Residents' bill of rights entitles all residents in City Homes to receive care of the highest standard, to be treated with dignity and respect and to live in an environment that is free from threats, fear and injustice.
Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from the other residents, families, volunteers or employees. (For definition please see appendix A)
Violation of any aspect of this policy with lead to disciplinary action up to and including dismissal."

As per LTCHA, 2007, c. 8, s.3. (1), "Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident dignity.
2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and care for in a manner consistent with his or her needs…

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

S. 2. (2) (a) defines "physical abuse" as:
"the use of physical force by anyone other than a resident that causes physical injury or pain"

Log # 005481-17:
A Critical Incident (CI) was submitted to Ministry of Health and Long-Term-Care

(MOHLTC) related to an allegation of staff to resident physical abuse.

Resident # 001 was admitted to the home with several diagnoses.

It is documented in the CI report that resident's family member indicated that PSW #117 was observed to be physically abusive toward resident #001 on a specified day.

Resident #001 was sent to hospital for an assessment. The emergency room assessment report from that day was reviewed by Inspector #126 and indicated that resident #001 did not sustain physical injury from the incident.

The day after the specified day, Inspector #126 observed resident #001 who was resting quietly in bed with two 1/4 rails up. Inspector #126 was unable to interview resident #001 related to a language barrier and resident #001 did not appear to understand when he/she was asked how he/she was. Resident #001 responded to Inspector #126 by smiling at her. The bed was observed to be at the lowest level and a rubber mat was beside the resident's bed on the right side. No injuries were observed on the resident.

Based on a review of the evidence provided by the family, Registered Practical Nurse (RPN) #102 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on a review of the evidence provided by the family, RN #101 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on a review of the evidence provided by the family, the ADLTCHB indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

During the course of this inspection, Inspector #126 reviewed the evidence related to the incident. The evidence demonstrated that on a specified day, PSW #117 was physically abusive toward resident #001.

PSW #117 did not comply with the licensee's abuse policy by not treating resident #001 with respect and dignity and free from threats, fear, emotional and physical abuse. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Care Policy: Skin Integrity, # 355.29, last reviewed in February 2017, was complied with, by not documenting the dressing changes of resident #001 as per policy.

In accordance with O. Reg. section.48 (1) "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin can wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

The home's Skin and Wound Care Policy: Skin Integrity, # 355.29, last reviewed in February 2017, requires the following:

"Procedure:

5. Implement the Altered Skin Integrity Assessment Tool (form 355.29B) where a resident has any skin breakdown, rashes, pressure ulcer/injury, skin tears or wounds.

6. Use Altered Skin Integrity Assessment Tool to document dressing changes, assessments and weekly documentation."

It was noted in the Medication Administration Record (MAR) of March to April 2016 that resident 001 was receiving a specific skin treatment.

It was noted that the dressing changes as per March 2016 directives were not documented on the Altered Skin Integrity Assessment Tool (ASIAT) for several days. The wound was healed by a specific day in July 2016.

On a specific day in September 2016, it was documented in the MAR of September to October 2016, resident #001 was receiving another specific skin treatment.

It was noted that the dressing changes as per September 2016 order were not documented on the ASIAT on three occasions between November and December 2016.

On the above identified dates the MAR and the progress notes were reviewed and there was no documentation related to the dressing changes.

RN #101 indicated to Inspector #126, that the dressings were probably done but were not documented. RN #101 indicated that nursing staff are expected to document the dressing change as per policy on the ASIAT. [s. 8. (1) (a),s. 8. (1)

(b)]

2. The licensee has failed to ensure that the Medication Administration Policy #345.3, last revised June 2016 was complied with, in that nurses continued to sign the Medication Administration Record (MAR) for resident #001 medications, when the medications were not included in the daily medication strip.

In accordance with O. Reg. 79/10, section.114. (2) "The licensee shall ensure that written policies and protocol are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home."

The home Medication Administration Policy #345.3, last revised June 2016 requires nurses to:
"There are 10 things to make sure are "right" when administering medication:
-The right medication
-The right time
-The right dose…"

Resident #001 was admitted to the home with several diagnoses.

Inspector #126 reviewed the MAR dated August to September 2016, and noted that resident #001's was prescribed several medications. On a specific day in August 2016, the physician prescribed a change in the dosage of three specific types of medication.

It was noted in the MAR dated August to September 2016, that the physician orders written on a specific day in August 2016 were transcribed correctly for the exception of the evening dose of a specified medication at bed time that remained on the MAR when it should have been discontinued. It was noted that the nursing staff continued to sign the MAR for the bed time specified medication for several doses after it was discontinued.

Inspector #126 reviewed the MAR dated September-October, 2016 and it was noted that the Pharmacy discontinued the medication as per the physician order of August 2016 and transcribed the accurate new dosage of the specified medication.

During a telephone interview, the Pharmacist of the home indicated to Inspector #126, that the new prescription of August 2016, was processed by the pharmacy

and the new medication strip with the changed dosage of the specified medication was sent to the home the next evening of August 2016. The pharmacy repackaged all the medications for the usual day of delivery. The Pharmacist indicated that resident #001could potentially have received extra doses of the specified medication for the period of three days as the home had the medication strip with the previous ordered dosage of the specified medication. After a specific day in September 2016 the corrected dosage of the specified medication was sent to the home. The AutoMed Report from pharmacy was reviewed and it was noted that the right dosage of the specified medication was sent to the home on that specific day of September 2016.

Therefore, resident #001 could potentially have received extra doses of the specified medication on three evening and that the other sign doses were not given as the specified medication was not available but the nurses continued to sign the MAR until a specific day in October 2016. (Refer to WN #5)

The licensee did not comply with the Medication Administration Policy #345.3 for not checking resident #001's medication strip to validate the right medication, the right dosage and the right time as they they would have identified that as of a specific day in September 2016, the pharmacy was sending the correct dose of the specified medication. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure documentation is completed as per skin and wound and medication administration policies, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's "Abuse Policy" -750.65 last revised September 2016 requires staff under the section:
"Practice:
The Homes are committed to zero tolerance of abuse or neglect to our residents. The Residents' bill of rights entitles all residents in City Homes to receive care of the highest standard, to be treated with dignity and respect and to live in an environment that is free from threats, fear and injustice.
Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from the other residents, families, volunteers or employees. (For definition please see appendix A)
Violation of any aspect of this policy with lead to disciplinary action up to and including dismissal."

As per LTCHA, 2007, c. 8, s.3. (1), "Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident dignity.
2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and care for in a manner consistent with his or her needs…

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

S. 2. (2) (a) defines "physical abuse" as:
"the use of physical force by anyone other than a resident that causes physical injury or pain"

Log # 005481-17:

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term-Care (MOHLTC) related to an allegation of staff to resident's abuse.

Resident # 001 was admitted to the home with several diagnoses.

It is documented in the CI report that resident's family member indicated that PSW #117 was observed to be physically abusive toward resident #001 on a specified day. Resident #001 was sent to hospital for an assessment.

The emergency room assessment report from that day was reviewed by Inspector #126 and indicated that resident #001 did not sustain physical injury from the incident.

The day after the specified day, Inspector #126 observed resident #001 who was resting quietly in bed with two 1/4 rails up. Inspector #126 was unable to interview resident #001 related to a language barrier and resident #001 did not appear to understand when he/she was asked how he/she was. Resident #001 responded to Inspector #126 by smiling at her. The bed was observed to be at the lowest level and a rubber mat was beside the resident's bed on the right side. No injuries were observed on the resident.

Based on the review of the evidence provided by the family, Registered Practical Nurse (RPN) #102 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on the review of the evidence provided by the family, RN #101 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on the review of the evidence provided by the family, the ADLTCHB indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

During the course of this inspection, Inspector #126 reviewed the evidence related to the specified incidents. The evidence demonstrated that on a specified day, PSW #117 was physically abusive toward resident #001.

PSW #117 did not comply with the licensee's abuse policy by not treating resident #001 with respect and dignity and free from threats, fear, emotional and physical abuse.

Log #006193-17
A Critical Incident (CI) was submitted to the MOHLTC related to an allegation of staff to resident physical abuse.

During the course of this inspection, Inspector #126 reviewed the evidence related to the specified incidents. In the evidence provided, Inspector #126 observed that PSW #126 did not close the resident's bedroom door, when the long sleeve top was removed and a t-shirt was put back on resident's 001.Resident #001 was not treated with respect and dignity by PSW #126 by not closing the door when care was provided. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff comply with the Abuse Policy, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license failed to ensure that no drug is used by or administered to a resident in the home unless the drug was prescribed for the resident. Resident #001 specified medication dosage was changed on a specific day in August 2016 and the nurses continued to administer the specific medication for three days when it was discontinued.

Inspector #126 reviewed the MAR dated August to September 2016, and noted that resident #001's was prescribed several medications. On a specific day in August 2016, the physician prescribed a change in the dosage of three specific types of medication.

Inspector #126 reviewed the MAR dated August to September 2016, and noted that the physician orders of that specific date in August 2016, were processed for the exception of the evening dose of the specified medication. The MAR were signed for several evening when it was discontinued as of that specific day in August 2016.

It was documented on the Medication Incident Report that on a specific day in September 2016, RPN #114 noted that she administered resident #001 the wrong dose of two specified medication. She held the evening dose of these medications. RPN #114 informed the family and completed a medication incident report. The incident report was reviewed and signed by the PMORC #109 on a specific day in September 2016. There was no adverse reaction to resident # 001.

The PMORC indicated to Inspector #126, that the Medication Incident Report of RPN #114 of that specific date of September 2016 was self-reported by RPN #114. Inspector #126, questioned the new physician order of August 2016 related to the change in dosage of the specified medication dose and the PMORC indicated that it was between the nurse and the physician that was doing the orders on the Doctor's day, to whether or not to continue the administration of the medication.

Furthermore, the PMROC, indicated that there was no specific policy for the management of medication error requiring nursing staff to call the physician. The PMROC indicated it was to the discretion of the nurse to call or not, the physician if there was a medication error. In this case, the physician was not called. The medication error was classified as a "Level 1: No Harm-an event that did reach the resident but did not cause harm".

Inspector #126 reviewed the MAR dated September-October 2016 and it was noted that the Pharmacy discontinued all the dose of the specified medication.

RPN #114 indicated to Inspector #126, that she realized she had given the wrong dosage of the medication to resident #001 on that specific day of September 2016. RPN #114, indicated that after the change in physician orders of August 2016, the medication strip was not identified with a "green label change in direction" for the new medication dosages and that the "old strips" were not removed. She indicated that Pharmacy send the medication to the home on the Friday afternoon and will sent the updated medication in the early evening the same day or the following day, depending on the time the order is processed.

The Physician indicated to Inspector #126, that on that specific day of August 2016, when he visited resident #001, he observed that the resident was too sedated and decreased the dosage of the medication. Inspector #126 clarified the evening dose of the specified medication with the physician and he indicated that what was ordered on that specific day of August 2016, was the total daily dosage of the specified medication and resident #001 was not to be administered an extra daily dose during the evening.

The Pharmacist indicated to Inspector #126, that the changed in medication of August 2016, and the new dosage of the three types of medications was sent to the home the evening of that specific day in August 2016. The pharmacy repackaged all the medications for the usual delivery. The Pharmacist indicated that resident # 001 was potentially administered extra doses only that week because after that September delivery there was only the corrected dosage as prescribed by the physician available for administration.

Resident #001 received extra doses of three doses of a specified medication, therefore the licensee failed to administer a specified medication as prescribed by the physician. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure physician order for administering medication, to be implemented voluntarily.

WN #6: 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,
(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 failed to ensure that resident #001 was repositioned every two hours or more frequently while sitting in the w/c.

Resident #001 was admitted to the home with several diagnoses.

Resident #001's plan of care, requires staff to use the following intervention related to repositioning; "repositioned every 2 hours when he/she is in the chair or in bed". Resident #001 is dependent on staff for repositioning himself/herself when sitting in the w/c.

Inspector #126, observed resident #001 to be sitting in the wheel chair (w/c) at lunch time in the dining room. After being fed his/her lunch, PSW #106 took

resident #001 to the lounge to watch television. Later that day, resident #001 was observed to be sitting in the lounge in the w/c at the same place and in the same position as he/she was first observed. Resident #001 was not repositioned for a period of 3.5 hours while sitting in the w/c.

RN #101 indicated to Inspector #126, that resident is usually taken out of bed around 1100 hours and is put back to bed after supper. She also indicated that the resident does not like to be in a tilt position and responds by yelling and calling out. RN #101 indicated that for positioning of resident #001 that sometime he/she can move "a bit in the chair". RN #101, indicated that there was no specific interventions for positioning resident #001 while sitting in the w/c.

PSW #106 indicated to Inspector #126, that resident #001 is left in the lounge sitting up in the w/c for the afternoon. After lunch, PSW #106 demonstrated to Inspector #126, when he/she tilted resident #001's w/c, resident started to shout and yell. Resident #001 was immediately put back in an upward position and the behaviors stopped.

RPN #105 indicated to Inspector #126, that resident #001 is usually put back to bed after supper. When asked about the repositioning, RPN #105 indicated that he/she is not sure about the repositioning interventions when resident #001 is in the w/c but he/she indicated that resident #001 is repositioned every 2 hours when in bed.

PSW #107 indicated to Inspector #126, that resident #001 does not like to have the chair tilted and that he/she does not reposition him/her when he/she is siting in the w/c. PSW #107,indicated that after resident is back in bed, he/she repositions the resident every 2 hours.

Resident #001 was not reposition every two hours of more frequently while sitting in the w/c as identified in the plan of care. [s. 50. (2) (d)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #001 had a weight change of 5 per cent of his/her body weight between August 2016 and September 2016. Resident #001 was not reassessed by the RD at that time.

Resident # 001 was admitted to the home with several diagnoses.

Inspector #126 reviewed the monthly weight record and noted that between August 2016 and September 2016, resident #001 had a weight change of 5 per cent.

The RD indicated to Inspector #126, that on a monthly basis, she gets a monthly email from the PMORC regarding the weight loss of residents in the home. The RD indicated that she does not keep a copy of the residents monthly weight reports email. The RD also indicated that she prints the monthly report of all the residents in the home and follows up with the residents that have a weight loss and usually request a reweight. She does not know why resident #001 weight change was missed in September 2016.

The FSS #104 indicated to Inspector #126, that she reviews the resident's monthly weight report and does not know how resident #001 was not reassessed in September 2016. FSS #104 indicated that the quarterly assessment are usually completed by the RD.

The PMORC indicated to Inspector #126, indicated that she had not received any notification related to resident #001 weight loss in September 2016.

RN #101 indicated to Inspector #126 , that she reviewed the emails sent by the PMROC for September 2016 but was unable to locate any email regarding resident #001 September 2016 weight loss.

Resident #001, had a change of 5 per cent of body weight, or more, over one month and was not reassessed by the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 9 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDA HARKINS (126) - (A1)

Inspection No. / No de l'inspection : 2017_620126_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004643-17, 005481-17, 006193-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 09, 2017;(A1)

Licensee / Titulaire de permis :

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2

LTC Home / Foyer de SLD :

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tony Sponza

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To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee shall prepare, submit and implement a plan to ensure the plan includes:

The development and implementation of an ongoing monitoring process to ensure resident #001's interventions related to transfer, repositioning and weight management as set out in the plan of care, is provided.

The licensee shall ensure that a document record of ongoing monitoring processes are kept in the home that includes; the name of the staff member conducting the resident specific review for transfer, repositioning and weight management, the date and time of the review and the improvements made in response to any discrepancies found between the provision of the resident's care and the plan of care.

This plan must be submitted in writing by September 15, 2017 to Linda Harkins, LTCH Inspector at 347 Preston Street, 4th floor, Ottawa Ontario, K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure to position resident #001, in bed, as specified in the plan of care.

Resident #001's plan of care, requires staff to use a specified intervention related to risk for bed entrapment.

During the course of this inspection, Inspector #126 reviewed the evidence related to identified incidents. PSW #117 was observed positioning resident #001 in bed for the night without the intervention as specified in the plan of care. On another identified date, PSW #126 and PSW #127 were observed positioning resident in bed for the night, without the intervention as specified intervention.[s. 6. (7)]

2. The licensee has failed to provide Fortified Mashed Potatoes (FMP), twice daily to resident #001.

Resident #001 was admitted to the home with several diagnoses.

Resident #001's plan of care, indicated that resident was to received fortified mashed potatoes twice a day. On a specific day in May 2016, the Registered Dietitian (RD) completed the quarterly assessment and documented in the progress notes that resident #001 had a gradual weight loss in 6 months. The RD ordered to start FMP, twice a day to supplement intake and support weight maintenance. On a specific day in August 2016, the RD documented in the progress notes that she observed resident #001 during a meal observation to be receiving the FMP at that time.

On a specific day in November 2016, the RD completed the quarterly assessment and documented in the progress notes that resident #001 has had significant weight loss in 3 months and that the weights were stable from September to November. On that same day, the RD documented in the progress notes that she had ordered FMP in May 2016, but when she observed resident #001 during a meal observation at lunch time, she noted that the resident did not receive the FMP. The RD reviewed the "houselist" to ensure resident #001 was on the list to receive the FMP and noted that resident #001 was not on the November 2016 list. On a specific day in November 2016, the RD reordered the FMP twice a day to supplement intake and support weight maintenance.

Interview with the Registered Dietitian (RD), indicated to Inspector #126, that on a specific day in November 2016, she observed the resident at meal time and noted that the FMP was not given. The RD indicated that when she orders any type of supplement for residents, the process is to document the order in the communication book and the information is reviewed by the Food Service Supervisor (FSS), it is then communicated to the kitchen for preparation and it is added to the "houselist". The RD indicated that she did not know how long the resident did not get the FMP but it was highly unlikely that resident #001 did get the FMP for several days in November 2016 as resident #001 was not on the "houselist" of November 2016.

Interview with the FSS #104, indicated to Inspector #126, that he/she did not know when or why resident #001 was not receiving FMP in November 2016. FSS #104 indicated that the process for dietary orders are to be written in the communication book by the RD. FSS #104 reviewed the communication book and noted that the RD ordered FMP twice, on a specific day in May and November 2016. The FSS indicated that they do not keep the monthly copies of the "houselist" and was unable to identify exactly when resident #001 stopped receiving the FMP.

On a specific day in November 2016, the RD observed that resident #001 not receiving for several days the FMP as specified in the plan of care. [s. 6. (7)] [s. 6. (7)]

3. The licensee has failed to ensure that resident #001 was transferred from his/her wheelchair (w/c) to the bed with the assistance of two persons as specified in the plan of care.

Resident #001's plan of care, requires staff to use the following intervention related to transfer "requires the assistance of 2 or more persons and that the mechanical lift may be used as resident not able to weight bear".

During a telephone conversation with resident's #001 family member, Inspector #126 was informed that PSW #117 was observed on a specified day to be transferring resident #001 from the wheel chair (w/c) to the bed independently without the assistance of another staff.

During an interview, Registered Nurse (RN) #111 indicated to Inspector #126 that an interview was conducted with PSW #117 who had worked on that specific day. RN

#111 asked PSW #117 if assistance was requested from a colleague and PSW #117 said that no assistance was requested to transfer resident #001.

During an interview, PSW #112 indicated to Inspector #126, that she/he worked on that specific day and was working in team with PSW #117. PSW #112 indicated that PSW #117 did not request assistance to transfer resident #001.

During an interview, PSW #116 indicated to Inspector #126, that he/she worked on that specific day for a short shift. PSW #116 indicated that he/she did not provide assistance to PSW #117 in transferring resident #001 from the w/c to the bed nor was asked to provide assistance.

During an interview, the Acting Director Long Term Care Home Branch (ADLTCHB), indicated to Inspector #126, that with the evidence provided to the Home, the evidence revealed that PSW #117 was transferring resident #001 from the w/c to the bed independently without the assistance of another staff.

A review of the evidence by Inspector #126 related to the identified incident revealed that PSW #117 was transferring resident #001 from the w/c to the bed independently without the assistance of another staff.

The licensee has failed to ensure that resident #001 was transferred by 2 person's transfer as per the plan of care. [s. 6. (7)]

In this matter, the scope was isolated, however, the Compliance Order is supported as resident #001 had a significant weight loss, was not reassessed, did not received his/her nutritional supplement and was not repositioned as specified in the plan of care.

A compliance order is warranted due to the severity of actual harm to resident #001. The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s.6 (7). Most recently, a Compliance Order was issued on June 21, 2017 as a result of inspection 2017_584161_007, a Written Notification was issued on October 17, 2016 as a result of inspection #2016_286547_0024. Prior to this, there has been non-compliance issued to the licensee on the following dates: two Written Notifications were issued on July 13, 2016 as a result of inspection #2016_285126_0013; one Written Notification was issued on July 13, 2016 as a result of inspection #2016_285126_0012; one Written Notification was issued on June 2, 2016 as a

result of inspection #2016_200148_0011; one Written Notification was issued on February 11, 2016 as a result of inspection #2016_287548_0002; one Voluntary Plan of Corrective Action was issued on June 18, 2015 as a result of inspection #2015_362138_0017.[s. 6. (7)]
(126)

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

Dec 01, 2017(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
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).

The licensee shall develop a plan to ensure:
1. The written policy titled "Abuse - 750.65" is effectively implemented by verifying that staff have a true understanding of all aspects of the policy, with a focus on the definitions of abuse and the Residents' Bill of Rights, and the definitions of abuse and neglect and demonstrate knowledge related to abuse, and,

2. that nursing staff providing direct care The licensee shall ensure that staff understand and demonstrate knowledge of the Residents' Bills of Rights, including cultural values, language barriers and individualized care needs of residents, and,

3. that the efficacy of every measure included in the required plan is evaluated on a regular basis to promptly address any identified deficits in knowledge and practice.

This plan must be submitted in writing by September 15, 2017 to Linda Harkins, LTCH Inspector Nursing at 347 Preston Street, 4th floor, Ottawa Ontario K1S 3J4 OR by fax at 613-569-9670.

Grounds / Motifs :

(A1)
1. The licensee has failed to protect resident #001 in that PSW #117 did not comply with the home's Abuse Policy # 750.65, revised September 2016.

The licensee's "Abuse Policy" -750.65 last revised September 2016 requires staff under the section:
"Practice:
The Homes are committed to zero tolerance of abuse or neglect to our residents. The Residents' bill of rights entitles all residents in City Homes to receive care of the highest standard, to be treated with dignity and respect and to live in an environment that is free from threats, fear and injustice.
Residents will not be subjected to any form of physical, emotional, sexual, verbal or

financial abuse or neglect from the other residents, families, volunteers or employees. (For definition please see appendix A)
Violation of any aspect of this policy with lead to disciplinary action up to and including dismissal."

As per LTCHA, 2007, c. 8, s.3. (1), "Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident dignity.
2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and care for in a manner consistent with his or her needs…

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

S. 2. (2) (a) defines "physical abuse" as:
"the use of physical force by anyone other than a resident that causes physical injury or pain"

Log # 005481-17:
A Critical Incident (CI) was submitted to Ministry of Health and Long-Term-Care (MOHLTC) related to an allegation of staff to resident physical abuse.

Resident #001 was admitted to the home with several diagnoses.

It is documented in the CI report that resident's family member indicated that PSW #117 was observed to be physically abusive toward resident #001 on a specified day.

Resident #001 was sent to hospital for an assessment. The emergency room assessment report from that day was reviewed by Inspector #126 and indicated that resident #001 did not sustain physical injury from the incident.

The day after the specified day, Inspector #126 observed resident #001 who was

resting quietly in bed with two 1/4 rails up. Inspector #126 was unable to interview resident #001 related to a language barrier and resident #001 did not appear to understand when he/she was asked how he/she was. Resident #001 responded to Inspector #126 by smiling at her. The bed was observed to be at the lowest level and a rubber mat was beside the resident's bed on the right side. No injuries were observed on the resident.

Based on a review of the evidence provided by the family, Registered Practical Nurse (RPN) #102 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on a review of the evidence provided by the family, RN #101 indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

Based on a review of the evidence provided by the family, the ADLTCHB indicated to Inspector #126, that the evidence revealed that on the specified day, PSW #117 was physically abusive toward resident #001.

During the course of this inspection, Inspector #126 reviewed the evidence related to the incident. The evidence demonstrated that on a specified day, PSW #117 was physically abusive toward resident #001.

PSW #117 did not comply with the licensee's abuse policy by not treating resident #001 with respect and dignity and free from threats, fear, emotional and physical abuse. [s. 19. (1)]

A Compliance Order is warranted due to potential harm to resident #001. The scope is isolated. The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s. 19(1). Most recently, a Compliance Order was issued on June 21, 2017 as a result of inspection 2017_584161_007. Prior to this two Compliance Order were issued to the licensee on June 2, 2016 as a result of inspection #2016-200148-0011 and on April 7, 2015 as a result of inspection #2015-2865-0002.
(126)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Dec 01, 2017(A1)

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
Télécopieur : 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 9 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

Service Area Office /
Bureau régional de services : Ottawa