Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jan 18, 2018	2017_655679_0015	026451-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE NORTH YORK ON M2L 1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

MICHELLE BERARDI (679), NATASHA MILLETTE (686), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): December 11-15, and 18-21, 2017.

Additional logs inspected during this RQI included:

- Two Critical Incidents the home submitted to the Director regarding staff to resident abuse/neglect.

- One Follow-Up log regarding compliance orders #001 and #002, issued during inspection #2017_491647_0006, regarding s. 8. (3) of the Long Term Care Homes Act (LTCHA), 2007, related to registered nursing staffing and s. 19. of the LTCHA, 2007, regarding duty to protect.

- One Follow-Up log regarding compliance orders #001, #002 and #003, issued during inspection #2017_653648_0004, regarding s. 5. of the LTCHA, 2007, regarding safe and secure home, s. 6. (7) of the LTCHA related to plan of care and s. 36 of the Ontario Regulation (O. Reg) 79/10, related to safe transferring and positioning.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Environmental Services Manager, Social Services Manager, Environmental Coordinator, Pharmacist, Registered Dietitian (RD), Consultant, Communicator, Intervener, Registered Nurses (RNs), Registered Practical Nurses (RPNs), student nurse, Personal Support Workers (PSWs), Housekeeping staff, Environmental staff, family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
5 VPC(s)
1 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**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2017_491647_0006	686
O.Reg 79/10 s. 36.	CO #003	2017_653648_0004	679
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2017_653648_0004	679
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2017_491647_0006	627

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

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

A previous compliance order (CO) #002 was issued on June 5, 2017, to address the licensee’s failure to comply with s. 6.(7) of the LTCHA, 2007, within report #2017_653648 _0004. The compliance order instructed the home to complete the following:

1) Within one week of receipt of this order, review resident #005, #013, #014 an #012's plan of care with all direct care staff responsible for the resident's care to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.
2) Develop and implement a quality improvement process to ensure that all residents, specifically residents #005, #013, #014 and #012 receive the care as specified in his or her plan of care.
3) Document all required steps in 1-2 noted above.

The home was ordered to be in compliance with the aforementioned legislation by August 21, 2017. While the licensee complied with part one and two of the order, non-compliance was identified related to the care residents #005, #013 and #014 were to have received. Additional non-compliance was also observed related to this provision.

Resident #004 was identified during a staff interview as experiencing a change in weight.

Inspector #627 reviewed the resident's plan of care and identified that the resident was to receive an intervention, at specified intervals.

On December 13, 2017, Inspector #627 observed resident #004. The Inspector observed the resident for a specified period and noted that the resident was not offered their specified intervention.

Inspector #627 interviewed student #110 who stated that they had provided the resident with fluids. Student #110 was unsure if the resident had received their specified intervention.

On December 19, 2017, Inspector #627 observed resident #004. The resident was not provided with their specified intervention.

Inspector #627 interviewed PSW #116 who stated that they were unsure if the intervention was provided to the resident.

Inspector #627 observed the resident in their room at a specified time. When Inspector #627 inquired about the specified intervention, RN #130 stated that they had forgotten to provide the specified intervention to the resident at a specific time, although they had documented that they had provided the intervention.

Inspector #627 interviewed the DOC who stated that resident #004 should have received their specified intervention. The DOC stated that if the resident was not provided with the intervention, then the documentation should have supported that it was not provided. The DOC stated that if the resident had been in a specified location that they should have been provided with the intervention. The DOC identified that the resident's plan of care had not been followed.

2. During a resident interview, resident #005 informed Inspector #627 that they had a sleep preference. Resident #005 stated that they were usually woken at a particular time and would like to be woken at a different time.

Inspector #627 reviewed resident #005's care plan in effect at the time of the inspection

and identified a focus for their sleep pattern, which indicated that resident #005 rose at a certain time.

Inspector #627 observed resident #005 sitting dressed in their room at a specific time, which was not as they had requested or as indicated in the care plan.

Inspector #627 interviewed PSW #107 who stated that they would first go in resident #005’s room at a specified time. If the resident was not up by a specified time, they woke them up. The PSW further stated that there was nothing in the resident’s care plan to address their preferred time to rise in the morning and that they ensured that resident #005 was up by a certain time.

Inspector #627 interviewed RPN #129 who stated that resident #005 was independent and able to make their own decisions. They stated that the resident should not be woken up before a specific time if they were sleeping, as this was their preference. If the resident missed breakfast, a meal tray could be put aside for them. The RPN identified that the care was not provided to resident #005 as per their care plan in regards to their sleep preference.

Inspector #627 interviewed the DOC who stated that the resident’s sleep pattern and preferences were documented in the resident’s care plan. It was the expectation that staff would follow the care plan. The DOC identified that if a resident wanted to sleep past a specific time, then the kitchen saved a meal tray for them. The DOC stated that resident #005 was able to make their own decisions and that their sleep preference should be respected. The DOC identified that the resident’s plan of care was not followed in regards to their sleep routine.

3. During a resident interview on December 18, 2017, resident #007 informed Inspector #627 that they had concerns regarding the time they received their care and having to go to the dining room dressed other than their preference on certain days. The resident stated that they previously received their care at a certain time, however, a number of months ago, a staff member had informed them that they would now be receiving their care at a different time. The resident stated that they felt this was not right and that this person had no business changing their schedule. The resident identified that it was unacceptable for them to have to go to the dining room not dressed as they wished to be. Resident #007 stated that they had voiced their concerns to staff.

Inspector #627 reviewed resident #007’s care plan in effect at the time of the inspection

and noted that under a specific focus, the resident was supposed to receive their care on specific days at a certain time.

Inspector #627 interviewed PSW #123 who stated that it was the home's policy that certain care was provided at a specified time. The PSW further stated that they would attempt to perform care for resident #007 at a specific time as they would be upset if they were not cared for at a specific time.

Inspector #627 interviewed the Nurse Manager who stated that they were unsure why resident #007's schedule had been changed, as they were not in charge of the schedule then. They stated that resident #007 could and should have their care provided as per their preference. The Nurse Manager stated that they would speak with the resident to address their care needs and preferences.

On December 20, 2017, Inspector #627 reviewed the resident's care plan which had been updated to reflect the residents preferences.

Inspector #627 interviewed resident #007 in their room on December 20, 2017. Resident #007 stated that they had been told by a PSW that the home was short staffed, therefore they would receive their care at a different time. The resident identified that wearing clothes which were not their preference to the dining room because the care they preferred was not completed was unacceptable.

Inspector #627 interviewed PSW #132 who stated that they had been made aware during report that resident #007 was to receive their preferred care at a specific time. PSW #132 indicated that they had approached the resident and informed them that they were short one staff member, therefore, the resident would receive their care at a different time. The PSW further stated that it was their policy to have care completed at a certain time. Further, PSW #132 identified that they had 16 residents to get up and ready for breakfast in one and a half hours, therefore there was no time to complete some care for residents before a specific time. PSW #132 stated that they could not foresee the resident receiving their preferred care at their specified time at any time, as staff were to busy at that time.

Inspector #627 interviewed RPN #104 who stated that they had discussed during report that resident #007 was to have care provided at a specified time as per their care plan. RPN #104 stated that they were aware that PSW #132 had informed the resident that they were short staffed, therefore, they would be provided with the care at a different

time.

On December 20, 2017, during a telephone interview with the Nurse Manager, they stated that at one time, PSWs would complete specific care at a specific time and that the residents had felt rushed. For this reason, it was decided by the Director of Care that some care would be completed at a different time unless it was stipulated in their care plan. The Nurse Manager substantiated that care was not provided as per the care plan in regards to resident #007 receiving their preferred care at a specific time.

4. Inspector #686 reviewed resident #013's current plan of care which indicated that staff were to provide the resident with a specified intervention related to their dietary requirements.

On December 19, 2017, Inspector #686 observed resident #013. The resident was not provided with their specified intervention.

Inspector #686 interviewed PSW #107 and asked if resident #013 had their intervention provided to them. PSW #107 verified that the resident was supposed to have their intervention at a specific time and acknowledged that this had not occurred. PSW #107 indicated that resident #013 should have their intervention provided to them as specified in the care plan.

Inspector #686 interviewed RPN #129, who verified that they did not observe the resident being provided with their intervention. The RPN acknowledge that they were unaware of the intervention in the resident's care plan.

Inspector #686 interviewed the ADOC who verified that staff should be following the care that was outlined in the residents care plan. The ADOC indicated that staff should have offered the intervention as specified in resident #013's care plan.

5. Inspector #686 reviewed resident #014's current plan of care, which indicated that resident #014 had a specific intervention to be in place at all times, related to responsive behaviours.

On December 19, 2017, Inspector #686 noted that the intervention was not in place. Further, Inspector #686 noted on four additional occasions that the intervention was not in place.

Inspector #686 interviewed PSW #107 who verified that the intervention was not in place. The PSW indicated that it was not always implemented. PSW #107 indicated that they had not seen the intervention being implemented in a while. The PSW acknowledged that the intervention was to be implemented as specified in the plan of care.

Inspector #686 interviewed RPN #129 who verified that the intervention was not in place. The RPN indicated that it was often used, especially at a specific time.

Inspector #686 interviewed the ADOC, who verified that staff should be following the care that is outlined in the resident's care plan. The ADOC indicated that resident #014's intervention was sometimes removed by another resident. The ADOC further indicated the when the intervention went missing, staff were to report it to the registered staff or management, so that it could be replaced and used.

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Resident #008 was identified as experiencing a fall through their Minimum Data Set (MDS) assessment.

Inspector #679 reviewed resident #008's care plan which identified that staff were to check the resident at a specified interval.

Inspector #679 reviewed the “Resident Checks” document for December 2017, and identified that signatures were missing on a number of occasions.

A review of the policy entitled “Falls Prevention and Management: NUR-V-165”, last revised in October 2017, identified that “all assessment, reassessments, interventions and the resident's responses to interventions will be documented. The documentation will be clear, concise, factual and complete”.

In an interview with PSW #131, they identified that resident #008 was on checks at a specified interval, and that the checks were to be documented on the paper checklists.

In an interview with RPN #111 they identified that resident #008 was on checks at a specified interval. Further, RPN #111 identified that the checks were to be charted on the paper checklists.

In an interview with Nurse Manager #103 they identified that when a resident was on checks they were to be documented on the paper checklists. Inspector #679 reviewed the checklist for resident #008 with Nurse Manager #103. The Nurse Manager identified that the documentation was to be completed at the specified duration with each resident check, and should have been completed for resident #008. [s. 6. (9)]

7. During three observations, Inspector #686 observed resident #013 awake in their wheelchair.

Inspector #686 reviewed resident #013's current plan of care which indicated that staff were to complete checks at a specified interval while the resident was in their wheelchair.

Inspector #686 reviewed the check sheets located at the nursing station, and was unable to locate a check sheet for resident #013.

Inspector #686 interviewed PSW #107 who indicated that resident #013 was on safety checks at a specified interval as they were at risk for falls. These checks were kept on a sheet of paper located on a clipboard at the front desk. PSW #107 verified that they were unable to locate where they would document the checks for resident #013 while in their wheelchair as there was no paper checklist, nor a task on Point of Care (POC).

In an interview with Inspector #686, RPN #129 acknowledged that staff were to complete the checks for resident #013 when they were in their wheelchair. RPN #129 verified that there were no sheets for the staff to document that the checks were completed for resident #013. RPN #129 identified that they were unsure as to where the checks were to be documented.

Inspector #686 interviewed the Nurse Manager who indicated that they kept a current list of all the residents requiring checks. The Nurse Manager verified that their list indicated that resident #013 was to be on safety checks at a specified duration while in their wheel chair. The Inspector informed the Nurse Manager that there had been no sheets for safety checks for resident #013. The Nurse Manager acknowledged that a check sheet should have been printed off and completed. [s. 6. (9) 1.]

8. The licensee has failed to ensure that the plan of care was 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 was no longer necessary.

A review of resident #005's current care plan identified that registered staff were to provide them with an intervention with specific instructions related to their dietary requirements.

During an observation, Inspector #686 observed resident #005 with their intervention. The intervention was not provided as per the instructions in the care plan.

Inspector #686 interviewed PSW #107 who indicated that resident #005's intervention was provided in a specific manor. PSW #107 identified that providing the intervention was the responsibly of the RPN.

In an interview with RPN #129 they identified that resident #005 received their intervention in a specific manor. The intervention was not provided as per the instructions in the care plan. RPN #104 identified that resident #005 received their intervention in a different manor then outlined in the care plan. RPN #104 identified that staff used to provide resident #005 their intervention as per the directions outlined in the care plan, however, this was no longer the practice as the resident would refuse the intervention. RPN #104 acknowledge that the care plan should have been updated to reflect the change.

In an interview with the ADOC they acknowledged that the RPN should have updated resident #005's care plan to reflect the changes to the instructions for the intervention.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”. 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 ensuring that the provision of care set out in the plan of care related to safety checks for residents is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the policy was complied with.

According to r. 49. (1) of the Ontario Regulation 79/10, the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review if residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

a) Resident #008 was identified as experiencing a fall through a MDS assessment.

Inspector #679 reviewed the electronic progress notes and identified that resident #008 experienced a specific number of falls.

A review of the policy entitled “Falls Prevention and Management: NUR-V-165”, last revised in October 2017, identified that when a resident had fallen, the registered nursing staff were to communicate the information concerning the falls incident for the next two shifts. Further, the policy identified that registered nursing staff were to complete the “Fall Shift 2/Follow Up” and “Fall Shift 3/Follow Up” report in the resident’s progress notes in Point Click Care (PCC).

Inspector #679 observed the progress notes and identified that one of the Fall Shift/Follow Up notes were not completed for the fall occurring on a specific date. Further, the inspector observed that one of the Fall Shift /Follow Up notes were not completed for the fall occurring on a separate date.

b) Resident #009 was identified as experiencing a fall through a MDS assessment.

Inspector #679 reviewed the electronic progress notes and identified that resident #009 experienced a fall on a particular date. Inspector #679 observed the progress notes and identified that one of the Fall Shift /Follow Up notes were not completed for the fall occurring on a specified date.

In an interview with RPN #111 they identified that when a resident had fallen staff were to complete the post fall assessments numbered one, two and three in Point Click Care.

In an interview with the DOC, they identified that when a resident had fallen, staff should complete the post falls assessment, as well as, the "fall shift report two" and "falls shift report three". The DOC reviewed resident #008 and #009's profile and identified that they could not locate one of the "falls shift" reports for resident #008 for a specific number of their falls, nor a "fall shift" report for resident #009's fall.

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 ensuring that the home's policy entitled "Falls Prevention and Management: NUR-V-165" is complied with, specifically ensuring that post fall assessments are completed as outlined in the policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents and was complied with.

According to the LTCHA, 2007, and Ontario Regulation (O. Reg) 79/10, verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident’s sense of well-being, dignity or self-worth that was made by anyone other than a resident.

According to the LTCHA, 2007, and O. Reg 79/10, emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident

A CI report was submitted to the Director for an instance of alleged staff to resident verbal and emotional abuse. According to the CI report PSW #108 acted inappropriately towards resident #002.

Inspector #686 reviewed a written statement completed by PSW #108 which indicated that resident #002 was displaying responsive behaviours while the staff were assisting them. PSW #108 indicated that they acted inappropriately towards resident #002.

Inspector #686 reviewed the documentation from an interview conducted by Nurse Manager #103 with resident #002 after the incident. During the interview resident #002 indicated that they remembered what happened. The resident indicated that their feelings were hurt.

Inspector #686 reviewed PSW #108 personnel file, which indicated they were terminated for their actions.

Inspector #686 reviewed the home's policy titled ‘Zero Tolerance of Abuse and Neglect of Residents’ last revised January 30, 2017, which identified that the home was committed to zero tolerance of abuse or neglect of its residents. Furthermore it indicated that the policy was to be complied with.

Inspector #686 interviewed PSW #107 who verified that they had witnessed PSW #108

act inappropriately towards resident #002.

Inspector #686 interviewed Nurse Manger #103 who verified that they had been informed of the suspected abuse immediately after it occurred. The Nurse Manager indicated they interviewed resident #002 the day that the suspected abuse occurred. The resident identified that they were upset.

Inspector #686 interviewed ADOC #102 who indicated they conducted an investigation immediately. PSW #108 admitted that they had acted inappropriately. The ADOC acknowledged that PSW #108 had verbally and emotionally abused resident #002, had not followed the home's policy on Zero Tolerance of Abuse and Neglect and had not followed the training they received on abuse and neglect.

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 ensuring that the written policy promoting zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work.

Inspector #627 interviewed resident #007 in regards to specific aspects of their care. The resident stated that they had met with the Nurse Manager last evening to arrange their schedule as per their preference, however, they had been told that they would receive their preferred care at a different time due to staff shortages. See WN #1 for details.

Inspector #627 approached PSW #132 to arrange an interview time. The PSW replied to the Inspector that they were working alone and that they would not have time for an interview. Inspector #627 observed PSW #132 walking between two tables to assist three resident with their breakfast meal and encouraging other residents to consume their meals.

Inspector #627 reviewed the home's “Staffing Plan policy”, and could not identify a back-up plan for nursing and personal care staffing which addressed situations when staff could not come to work.

Inspector #627 interviewed RPN #104 who stated that PSW #132 had reported to them that they were the only PSW on the unit. It had been identified during shift report that there was a sick call for this shift. The registered staff who received the call would have tried to call in staff. If no one was available, the unit would work short. RPN #104 identified that there would be one PSW assigned to every unit and one PSW will float between units. RPN #104 identified that they would help, however they had a medication pass to do in the morning. RPN #104 identified that this is their routine, and that the home did not have a policy to manage these situations, that they were aware of.

Inspector #627 interviewed RN #115 who stated that when a staff member called in sick, they would call staff according to the union requirements. The home provided them with an electronic program which listed the order in which staff were called.

Inspector #627 interviewed the ADOC who stated that their back up plan was the collective agreement with their union, however it was not included in the staffing plan. They were required to call in staff as directed by the union.

Inspector #679 interviewed the DOC who stated that when a staff member called in and was unable to come to work, the registered staff member who received the call would place a call out to staff. The DOC identified that the staff schedule went by the seniority list as per the collective agreement.The DOC identified that other staff members may be asked to stay late to assist, come in early for their shift and that a staffing agency would be called. If no one was available, staff were to communicate with each other and work it out amongst themselves. They further stated that they were unsure if it was based on communication only or if the home had a formal plan as the Social Service Manager was in charge of the PSW staffing.

Inspector #679 interviewed the Social Service Manager who stated that their role was to work on scheduling ahead of time. If a sick call was received, the registered staff who received the call would attempt to replace the staff member by utilizing the "Staff Schedule Care" software as staff had to be called by seniority and the system prompted them to do so. If staff were not available, then a staffing agency was called to fill the vacant shift. The Social Services Manager identified that if registered staff were unable to complete the calls, they could ask the Social Services Manager to do so.

Inspector #627 interviewed the Administrator who identified that the home's staffing plan had not included a back-up plan when staff were unable to come to work. They explained

that the union member's collective agreement acted as their staffing plan. [s. 31. (3) (d)]

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 ensuring that the home's staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff can not come to work, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable too the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

During a resident interview, resident #007 informed Inspector #627 that they had concerns regarding the time they received their care and having to go to the dining room for breakfast not dressed as they preferred on specified days. Further, they identified that they wanted to be dressed appropriately to go to the dining room. Refer to WN #1 for details.

Inspector #627 reviewed resident #007's care plan and noted that the care plan had not indicated the residents preferences related to dressing.

Inspector #627 interviewed resident #007 in their room at a specific time. Resident #007 stated that they had been told by a PSW that the home was short staffed, therefore they would receive their care at a different time. The resident identified that wearing clothes which were not their preference to the dining room because the care they preferred was not completed was unacceptable.

Inspector #627 interviewed PSW #123 who stated that it was the home's policy that certain care was provided at a specified time. The PSW further stated that they would attempt to perform care for resident #007 at a specific time as they would be upset if they were not cared for at a specific time.

Inspector #627 interviewed the Nurse Manager who stated that resident #007 could be dressed as their stated preference. The Nurse Manager stated that they would speak with the resident to address their care needs and preferences.

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 ensuring that resident #007 is dressed appropriately, suitable to the time of day in keeping with their preferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

During a resident interview, resident #006 stated to Inspector #679 that they had to wake up for staff to assist them with care and their preference to wake had not been respected.

During an interview with Inspector #627 resident #006 stated that they were woken at a time which was not their preference. Resident #006 identified that they were not asked or could not remember being asked about their preferred time to wake, and that they had not complained.

Inspector #627 reviewed resident #006's current written plan of care in effect at the time of the inspection and could not identify a focus for sleep patterns.

Inspector #627 interviewed PSW #125 who stated that they were unsure as to what the care plan identified as resident #006’s preferred time to rise. They stated that if the resident rang, the staff would assist them to get up, otherwise they would get them up at

any time as they were not picky. PSW #125 reviewed the care plan with Inspector #627 and could not identify any preferred time for rising in the resident's current care plan.

Inspector #627 interviewed RPN #129 who stated that when a resident was first admitted, the "24 hour Admission Plan of Care" was utilized to determine the residents activities of daily living and preferences. The Registered staff went over the care areas with the resident and family member(s), and a plan of care was formulated based on the interview. RPN #129 stated that sleep and rest preferences were addressed in the dressing section. RPN #129 reviewed the care plan for resident #006 with Inspector #627 and could not identify an entry regarding the resident's preferred time to rise. RPN #129 stated that this would have to be changed after speaking with the resident about their preferred time to rise in the morning and their preferred time to retire at night time as this should be included in the care plan.

Inspector #627 interviewed the DOC who stated that the resident's preferred sleep routines were reviewed during the 24 hour admission care plan interview using the "24 hour Admission Plan of Care" form. Further, they stated that the resident's preferred sleep routine should be identified and added to their care plan. The DOC identified that resident #006's care plan had not identified the resident's preferred time for rising in the morning and retiring in the evening. They stated that if the resident had not identified a preference, then it would not have been added to the care plan and the PSW's routine would be followed which would be to start waking residents at 0630 hours, and start retiring residents to bed at 1900 hours. [s. 26. (3) 21.]

WN #7: 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 :

1. The licensee has failed to 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, at times or at intervals provided for in the regulations.

According to r. 221. (1) 1. of the Ontario Regulation 79/10, for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: Falls prevention and management.

According to r. 221. (2) 1. of the Ontario Regulation 79/10, all staff who provided direct care to residents are to receive the training provided for in subsection 76 (7) of the Act annually.

Resident #008 and #009 were identified as experiencing falls through a MDS assessment.

Inspector #679 reviewed the course completion record from Surge learning which identified that two staff members had not received their fall prevention and management training for 2016.

A review of the policy entitled “Falls Prevention and Management: NUR-V-165”, last revised in October 2017, identified that training was provided to all direct care staff, relevant to the staff's responsibilities on falls prevention and management annually based on the staff members assessed needs.

In an interview with the ADOC they identified that education for fall prevention is provided yearly. Further, they identified that it was the expectation that all staff members completed their education, and that they could not locate documentation to identify that the remaining two staff members completed their fall prevention and management education for 2016.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a mediation cart that was used exclusively for drugs and drug related supplies.

During a review of the home's medication incidents over a three month period, Inspector #627 noted an incident report dated a specific date, whereby a tablet of a particular medication was sent by the pharmacy provider for resident #016 in error. The medication was not given and was stapled to the medication report. The DOC informed the Inspector that the medication incident reports were kept in a location other than the medication room.

Inspector #627 reviewed the policy titled "Safe Storage of Mediation" (undated) which indicated that "all medications must be stored in a locked medication room or cabinet.

During a telephone interview with Inspector #627, the homes' pharmacy provider informed the Inspector that medication was packaged separately from other medication.

Inspector #627 interviewed RPN #111 who stated that if a drug was sent by mistake, they would call the pharmacy and try to return it so the resident was not charged for it. If it could not be returned they would dispose of it. Drugs that needed to be destroyed were brought to a medication room in the home, and placed in the destruction box. RPN #111 stated that any medication that could not be given could be held in the medication room until the end of the shift, however it had to be brought to the destruction box prior to leaving for the day.

Inspector #627 interviewed the DOC who stated that medications were to be stored in the medication rooms and the medication carts. The DOC stated that precautions had to be taken when handling this medication. The DOC stated that if a resident was sent a medication in error, the pharmacy was to be notified and the drug was to be discarded and destroyed as per policy. The DOC identified the medication that was sent to resident #016 should not have been stapled to the incident report and stored with the incident reports in a location other than the medication room as this was not a safe way to store the medication. The DOC identified that it should have been discarded as per the home's policy. [s. 129. (1) (a)]

Issued on this 19th day of January, 2018

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) : MICHELLE BERARDI (679), NATASHA MILLETTE (686), SYLVIE BYRNES (627)

Inspection No. / No de l'inspection : 2017_655679_0015

Log No. / No de registre : 026451-17

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

Report Date(s) / Date(s) du Rapport : Jan 18, 2018

Licensee / Titulaire de permis : THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2

LTC Home / Foyer de SLD : BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive, BARRIE, ON, L4M-0C4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Shirley Cassel

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To THE ONTARIO MISSION OF THE DEAF, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_653648_0004, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan which will ensure that the care set out in the plan of care is provided to all residents as specified in their plans, specifically ensuring that:

a) The care set out in the care plan is provided to resident #004 as specified, in relation to their dietary requirements;

b) The care set out in the plan is provided to resident #005 as specified, in relation to their sleep preferences;

c) The care set out in the plan is provided to resident #013 as specified, in relation to their dietary requirements;

d) The care set out in the plan is provided to resident #014 as specified, in relation to their responsive behaviours;

e) The care set out in the plan is provided to resident #007 as specified, in relation to their care preferences.

The plan must include a detailed auditing process to ensure that the care is being provided as specified. This plan should specifically include the individuals who will conduct the observations and the frequency of the observations.

The plan is due on February 2, 2018, and the order is to be complied with by February 16, 2018.

Grounds / Motifs :

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

A previous compliance order (CO) #002 was issued on June 5, 2017, to address the licensee's failure to comply with s. 6.(7) of the LTCHA, 2007, within report #2017_653648_0004. The compliance order instructed the home to complete the following:

1) Within one week of receipt of this order, review resident #005, #013, #014 an #012's plan of care with all direct care staff responsible for the resident's care to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.
2) Develop and implement a quality improvement process to ensure that all residents, specifically residents #005, #013, #014 and #012 receive the care as specified in his or her plan of care.
3) Document all required steps in 1-2 noted above.

The home was ordered to be in compliance with the aforementioned legislation by August 21, 2017. While the licensee complied with part one and two of the order, non-compliance was identified related to the care residents #005, #013 and #014 were to have received. Additional non-compliance was also observed related to this provision.

Inspector #686 reviewed resident #014's current plan of care, which indicated that resident #014 had a specific intervention to be in place at all times, related to responsive behaviours.

On December 19, 2017, Inspector #686 noted that the intervention was not in place. Further, Inspector #686 noted on four additional occasions that the intervention was not in place.

Inspector #686 interviewed PSW #107 who verified that the intervention was not in place. The PSW indicated that it was not always implemented. PSW #107 indicated that they had not seen the intervention being implemented in a while. The PSW acknowledged that the intervention was to be implemented as specified in the plan of care.

Inspector #686 interviewed RPN #129 who verified that the intervention was not in place. The RPN indicated that it was often used, especially at a specific time.

Inspector #686 interviewed the ADOC, who verified that staff should be following the care that is outlined in the resident's care plan. The ADOC indicated that resident #014's intervention was sometimes removed by another resident. The ADOC further indicated the when the intervention went missing, staff were to report it to the registered staff or management, so that it could be replaced and used.
(686)

2. Inspector #686 reviewed resident #013's current plan of care which indicated that staff were to provide the resident with a specified intervention related to their dietary requirements.

On December 19, 2017, Inspector #686 observed resident #013. The resident was not provided with their specified intervention.

Inspector #686 interviewed PSW #107 and asked if resident #013 had their intervention provided to them. PSW #107 verified that the resident was supposed to have their intervention at a specific time and acknowledged that this had not occurred. PSW #107 indicated that resident #013 should have their intervention provided to them as specified in the care plan.

Inspector #686 interviewed RPN #129, who verified that they did not observe the resident being provided with their intervention. The RPN acknowledge that they were unaware of the intervention in the resident's care plan.

Inspector #686 interviewed the ADOC who verified that staff should be following the care that was outlined in the residents care plan. The ADOC indicated that staff should have offered the intervention as specified in resident #013's care plan. (686)

3. During a resident interview on December 18, 2017, resident #007 informed Inspector #627 that they had concerns regarding the time they received their care and having to go to the dining room dressed other than their preference on certain days. The resident stated that they previously received their care at a certain time, however, a number of months ago, a staff member had informed them that they would now be receiving their care at a different time. The resident

stated that they felt this was not right and that this person had no business changing their schedule. The resident identified that it was unacceptable for them to have to go to the dining room not dressed as they wished to be. Resident #007 stated that they had voiced their concerns to staff.

Inspector #627 reviewed resident #007's care plan in effect at the time of the inspection and noted that under a specific focus, the resident was supposed to receive their care on specific days at a certain time.

Inspector #627 interviewed PSW #123 who stated that it was the home's policy that certain care was provided at a specified time. The PSW further stated that they would attempt to perform care for resident #007 at a specific time as they would be upset if they were not cared for at a specific time.

Inspector #627 interviewed the Nurse Manager who stated that they were unsure why resident #007's schedule had been changed, as they were not in charge of the schedule then. They stated that resident #007 could and should have their care provided as per their preference. The Nurse Manager stated that they would speak with the resident to address their care needs and preferences.

On December 20, 2017, Inspector #627 reviewed the resident's care plan which had been updated to reflect the residents preferences.

Inspector #627 interviewed resident #007 in their room on December 20, 2017. Resident #007 stated that they had been told by a PSW that the home was short staffed, therefore they would receive their care at a different time. The resident identified that wearing clothes which were not their preference to the dining room because the care they preferred was not completed was unacceptable.

Inspector #627 interviewed PSW #132 who stated that they had been made aware during report that resident #007 was to receive their preferred care at a specific time. PSW #132 indicated that they had approached the resident and informed them that they were short one staff member, therefore, the resident would receive their care at a different time. The PSW further stated that it was their policy to have care completed at a certain time. Further, PSW #132 identified that they had 16 residents to get up and ready for breakfast in one and a half hours, therefore there was no time to complete some care for residents before a specific time. PSW #132 stated that they could not foresee the resident

receiving their preferred care at their specified time at any time, as staff were to busy at that time.

Inspector #627 interviewed RPN #104 who stated that they had discussed during report that resident #007 was to have care provided at a specified time as per their care plan. RPN #104 stated that they were aware that PSW #132 had informed the resident that they were short staffed, therefore, they would be provided with the care at a different time.

On December 20, 2017, during a telephone interview with the Nurse Manager, they stated that at one time, PSWs would complete specific care at a specific time and that the residents had felt rushed. For this reason, it was decided by the Director of Care that some care would be completed at a different time unless it was stipulated in their care plan. The Nurse Manager substantiated that care was not provided as per the care plan in regards to resident #007 receiving their preferred care at a specific time. (627)

4. During a resident interview, resident #005 informed Inspector #627 that they had a sleep preference. Resident #005 stated that they were usually woken at a particular time and would like to be woken at a different time.

Inspector #627 reviewed resident #005's care plan in effect at the time of the inspection and identified a focus for their sleep pattern, which indicated that resident #005 rose at a certain time.

Inspector #627 observed resident #005 sitting dressed in their room at a specific time, which was not as they had requested or as indicated in the care plan.

Inspector #627 interviewed PSW #107 who stated that they would first go in resident #005's room at a specified time. If the resident was not up by a specified time, they woke them up. The PSW further stated that there was nothing in the resident's care plan to address their preferred time to rise in the morning and that they ensured that resident #005 was up by a certain time.

Inspector #627 interviewed RPN #129 who stated that resident #005 was independent and able to make their own decisions. They stated that the resident should not be woken up before a specific time if they were sleeping, as this was their preference. If the resident missed breakfast, a meal tray could be put aside for them. The RPN identified that the care was not provided to resident #005 as

per their care plan in regards to their sleep preference.

Inspector #627 interviewed the DOC who stated that the resident's sleep pattern and preferences were documented in the resident's care plan. It was the expectation that staff would follow the care plan. The DOC identified that if a resident wanted to sleep past a specific time, then the kitchen saved a meal tray for them. The DOC stated that resident #005 was able to make their own decisions and that their sleep preference should be respected. The DOC identified that the resident's plan of care was not followed in regards to their sleep routine. (627)

5. Resident #004 was identified during a staff interview as experiencing a change in weight.

Inspector #627 reviewed the resident's plan of care and identified that the resident was to receive an intervention, at specified intervals.

On December 13, 2017, Inspector #627 observed resident #004. The Inspector observed the resident for a specified period and noted that the resident was not offered their specified intervention.

Inspector #627 interviewed student #110 who stated that they had provided the resident with fluids. Student #110 was unsure if the resident had received their specified intervention.

On December 19, 2017, Inspector #627 observed resident #004. The resident was not provided with their specified intervention.

Inspector #627 interviewed PSW #116 who stated that they were unsure if the intervention was provided to the resident.

Inspector #627 observed the resident in their room at a specified time. When Inspector #627 inquired about the specified intervention, RN #130 stated that they had forgotten to provide the specified intervention to the resident at a specific time, although they had documented that they had provided the intervention.

Inspector #627 interviewed the DOC who stated that resident #004 should have received their specified intervention. The DOC stated that if the resident was not

provided with the intervention, then the documentation should have supported that it was not provided. The DOC stated that if the resident had been in a specified location that they should have been provided with the intervention. The DOC identified that the resident's plan of care had not been followed.

The decision to issue this compliance order was based on the scope which was determined to be a pattern, affecting more than the fewest number of residents involved, the severity, which indicated potential for harm, and the compliance history, which despite previous non-compliance's issued, including two written notifications (May 2017, report #2017_646618_0012 and March, 2016, report #2016_268604_0011) and one compliance order (June, 2017, report #2017_653648_0004) non-compliance continued with this section of the legislation. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Michelle Berardi

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