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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2017	2017_555506_0012	009915-17	Resident Quality Inspection

Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

LESLEY EDWARDS (506), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 25, 26, 29, 30, 31, June 1, 2, 6, 7, 8, 9, 13, 14, 15, 16 and 19, 2017.

During this inspection the inspections listed below were conducted concurrently:

Critical Incident Reports

006877-17- related to medication administration
007076-17- related to medication administration
007581-17- related to falls management
003374-17- related to medication administration
001619-17- related to medication administration

Complaints

031335-16- related to falls management
034160-16- related to plan of care
034225-16- related to plan of care, duty to protect, dining and snack services, transferring and positioning techniques, complaints procedure, housekeeping and cooling requirements
034565-16- related to nutrition and hydration and food quality
000394-17- related to bill of rights, nursing and personal care, skin and wound care, duty to protect and recreational and social activities, bathing and oral care
001848-17- related to plan of care, duty to protect and safe transferring and positioning techniques
005480-17- related to laundry services, falls prevention and prevention of abuse and neglect
002629-17- related to infection control practices and plan of care
006936-17- related to lack of supplies and food quality
011413-17- related to falls prevention
010787-17- related to staffing and qualifications of agency staff

Inquiries completed at the home

027862-16- breaches of confidentiality
006471-17- related to falls management
027563-16- injury of unknown cause
026951-16- related to improper treatment
029548-16- related to responsive behaviours and staffing
001567-17- related to falls prevention
032194-16- related to responsive behaviours
033744-16- related to alleged verbal abuse
034301-16- related to responsive behaviours
034606-16- related to improper treatment

008557-17- related to medication administration
001509-17- related to responsive behaviours
032312-16- related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Nursing Unit Clerk Supervisor, Nutrition Manager, Resident Assessment Instrument Co-ordinator (RAI), back-up RAI Co-ordinator, Resident Support Services Manager, Admissions and Social Services Coordinator, Maintenance Manager, Assistant Maintenance Manager, Registered Dietitians, Physiotherapist, registered nurses (RNs), registered practical nurses (RPNs), restorative staff, Personal Support Workers (PSWs), food service workers, laundry and housekeeping staff, residents and families.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **18 WN(s)**
- **11 VPC(s)**
- **1 CO(s)**
- **4 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) requires every licensee of a long term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and 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 policy Preventative Skin Care Program found in the Resident Services Manual revised October 2013, outlined the roles and responsibilities of team members. Health care aide/Personal Support Worker: reports abnormal or unusual skin conditions to the registered nursing staff , ie: red open areas, blisters, bruises, tears, scratches.

Resident #079 was observed by Inspector #585 to have areas of altered skin integrity on two areas identified in May 2017. A review of the clinical record for the resident, under the Point of Care (POC) tasks where the PSW's document care being performed, skin observations were noted to be completed on identified shifts in May and June 2017, with no skin concerns identified. PSW staff #109 was interviewed on an identified date in May 2017 and reported that a head to toe assessment was completed on a daily basis and also on all bath days. Registered staff reported that they were not aware of the areas of altered skin integrity on an identified date in May 2017, after the inspector brought it up to the PSW. The staff confirmed that the areas of altered skin integrity had not been reported to the registered staff as per policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. Ontario Regulation 79/10 section 136 subsection 2 outlined that the drug destruction and disposal policy must provide for any controlled substance that was to be destroyed and disposed of was to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.
B. Ontario Regulation 79/10 section 136 subsection (2) identified that the drug destruction and disposal policy must provide for drugs that were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based

practices and, if there are none, in accordance with prevailing practices.

The home's policy "Disposal of Medication (Poured or Wasted)", undated, directed staff that two registered staff were to sign for the disposal of narcotic or controlled drug on the Controlled Drug Administration Sheet.

On an identified date in December 2016, registered staff administered medications to a resident, and failed to properly account for the wasting of the controlled substance. The medications were charted on the narcotic sheet as being wasted. Review of the Controlled Narcotic sheet did not include a second registered staff signature. Interview with RN #114 confirmed that the registered staff did not follow the home's drug disposal policy, when they did not get a second registered staff to witness and sign for the wasted controlled substances. (528)

The home's procedure for opioid patch disposal included the use of the 'NH Opioid Patch Disposal Form' which directed staff to completed the following:
- affix used patch from the resident on this sheet in the numbered square - you may wish to use tape to ensure it is fixed
-store used sheets in a safe double locked area with other narcotics
-all sheets contain room for a maximum of five patches
-carefully remove the used patch from the resident
-carefully place the used patch in the appropriate square under the residents page for opioid disposal
-ensure that you initial and date the square that the used patch is placed on
-once the page is full ensure that it is placed with controlled substances for destruction by pharmacy
-avoid any direct contact with any patch
-do not return filled pages to pharmacy as these patches must be destroyed on site

On an identified date in April 2017, registered staff did not follow the home's procedure for removing patches from resident #024. Interview with RN #114 and RPN #136 confirmed that staff did not follow the home's patch disposal procedure. (528) [s. 8. (1) (b)]

3. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

A) In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) requires every

licensee of a long term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's program, "Falls Prevention Program – Subsection 4.1.12", last reviewed June 2015, Stated the interdisciplinary team will conduct the Fall Risk Assessment after any fall incident.

On an identified date in December 2016, resident #133 experienced a fall that resulted in an injury. The resident was transferred to the hospital and received treatment. Review of the clinical record revealed no Fall Risk Assessment was completed.
On an identified date in December 2016, resident #133 experienced a fall and a review of the clinical record revealed no Fall Risk Assessment was completed.
Interview with the DOC who confirmed the fall risk assessments were to be completed after each fall and near miss and confirmed the fall assessments were not completed as required. (585) [s. 8. (1) (b)]

4. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, r. 68 (2)(a), the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services.
The home's "Feeding and Hydration Program - Subsection 4.9.1", revised June 2015, outlined the following direction related to monitoring and evaluating fluid intake of residents:
"If the resident has not met their fluid needs for the day, Registered Staff must assess the resident for signs and symptoms of dehydration and document the results of the assessment in the resident's clinical record. If the resident's fluid intake is below their fluid needs for three consecutive days, the resident will be placed on Fluid Watch. A Dietary Referral is to be sent to the FSM/RD to communicate that the Fluid Watch has been stated and the FSM/RD will update the care plan."
i) Review of resident #133's plan of care indicated they had a specified fluid goal per day. Review of their fluid intake report from identified dates in January 2017, revealed they had not achieved their fluid goal for four consecutive days. Their plan of care identified refer to RD if intake was less than the specified amount for three consecutive days. Review of progress notes did not indicate the resident was placed on a fluid watch nor was documentation completed to demonstrate the resident had been assessed for signs

or symptoms of dehydration.
ii) Review of resident #088's plan of care indicated they had a specified fluid goal per day. Review of the resident's fluid intake records for identified dates in June 2017,revealed they did not meet their fluid goal. Their plan of care identified refer to RD if intake less than a specified amount for three consecutive days.
Review of progress notes did not indicate the resident was placed on a fluid watch nor was documentation completed to demonstrate the resident had been assessed for signs or symptoms of dehydration. Progress notes did not include notation of signs and symptoms of dehydration.
RPN #132 reported the home's process for monitoring hydration was to refer to the Registered Dietitian (RD) when fluid intake was less than the required amount, and to implement a "Sip and Go" program. RD #149 reported they included in each resident's plan of care to notify RD if less than a specified amount of fluid was consumed for three consecutive days; however, stated it was a general statement and not an individualized intervention. RD #149 and RPN #132 confirmed the home did not implement or follow what was directed in their Feeding and Hydration Program. (585) [s. 8. (1) (b)]

5. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy for 'Safe Handling and Assessing Residents', revised May 2017, defined acceptable transfers as follows:
i. Independent: this resident does not need physical aid rising from seated. Some verbal cuing and supervision may be necessary.
ii. One-Person Belt Transfer: This resident is full weight bearing, weighs 150lbs or less and needs assistance rising from a seated position.
iii. Two-Person Belt Transfer: This resident is full weight bearing, weighs greater than 150lbs and needs assistance rising from a seated position.
iv. Sit/Stand Mechanical Lift: This resident is partially weight bearing, can sit indendantly (to a certain degree) can follow instructions, and is behaviourally consistent
v. Total Mechanical Lift: This resident is non-weight bearing or otherwise unsuitable for the sit/stand lift.

A. An assessment from an identified date in March 2017, identified that resident #033 required one person physical assistance with all transfers and their care plan directed staff to provide one person extensive assistance with all transfers. Interview with PSW #129 confirmed that the resident required one person assistance with transferring and that they did not use a belt to transfer the resident. Interview with the PSW #128, PSW

#142, PSW #144 and RN #114 confirmed that the staff are not routinely using transfers belts when transferring the residents. Interview with the Physiotherapist and ADOC confirmed that the policy had been reviewed in May 2017, but did not reflect the current practice in the home of assisting residents to transfer safely with one and two person assistance without using transferring belts. (528)
B. On an identified date in March 2017, a Safe Lift and Transfer Assessment for resident #134 identified that the resident was able to weight bear, had responsive behaviours, a history of falls and required one person physical assistance.
i. Review of the written care plan identified that the resident required one to two person extensive assistance.
ii. Review of POC documentation from an identified date in March 2017, and interview with PSW # 142 and RPN #124 confirmed that staff were using one person to transfer the resident without a transfer belt as outlined in the plan of care.
Interview with RN #114 confirmed that the transfer status of the resident did not reflect the safe transfer assessment requirements in the home's policy. (528) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

The plan of care for resident #024 identified that they had symptoms related to diagnosis

and were receiving routine analgesic. The resident was not often compliant with the medication and a review of progress notes for resident #024 identified the resident had a history of not being compliant with the medication. Interview with RPN #136 confirmed the resident was often not compliant and staff were required to try interventions to prevent the resident from being non compliant. Review of the electronic medication administration record (eMARS) and the document the home referred to as the care plan did not include any information that the resident was non compliant with the medication administration. RPN #136 confirmed that the written care plan did not include specific directions to registered staff related to the resident's pattern of non compliance until after April 2017.
B. Review of resident #133's clinical record revealed that on an identified date in October 2016, their substitute decision maker (SDM) requested the resident be assessed by an outside service regarding their responsive behaviours and falls interventions be implemented. Later the same day, the resident experienced an unwitnessed fall with injury.
On an identified date in November 2016, the resident experienced an unwitnessed fall.
On an identified date in November 2016, the outside service conducted an assessment and made recommendations.
On an identified date in November 2016, the resident experienced a fall.
On an identified date in December 2016, the resident experienced a fall and sustained an injury and went to the hospital for treatment.
On an identified date in December 2016, a progress note was written regarding the fall that took place on an identified date in December 2016 which identified PSW did not follow the resident's plan of care.
On an identified date in December 2016, the resident experienced an unwitnessed fall.
On an identified date in December 2016, the resident experienced an unwitnessed fall.
On an identified date in December 2016, the resident experienced an unwitnessed near miss fall.
Additional interventions made by the outside service were not added to the resident's written plan of care until an identified date in January 2017. RN #141 confirmed the interventions made by the outside service related to responsive behaviours and falls prevention were not immediately added to the written plan of care.
Interview with RN #141 reported that recommendations made by the outside service were implemented; however, confirmed the written plan of care did not include the planned care for the resident regarding falls prevention strategies. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The plan of care for resident #079 under the focus of bed mobility indicated that the staff were to engage two assist bed rails. Under the focus of personal assistive safety device (PASD), staff were to apply one (quarter assist) bed rail when the resident was in bed. The resident's bed was observed to have two bed rails in the engaged position. Interview with the resident as well as registered staff #107 on an identified date in May 2017, confirmed the resident used both bed rails. The registered staff confirmed that the plan of care for the resident did not set out clear directions to staff and others who provided care to the resident in terms of the bed rails. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

On an identified date in May 2017, a progress note completed by RPN #116 identified that resident #033 had a fall and sustained an injury. A post fall assessment was completed using a clinically appropriate assessment tool a few days later by RPN #118 , which stated the resident did not have any injuries as a result of the fall. Interview with RPN #118, confirmed they completed the post fall assessment a few days late and were not aware the resident had sustained an injury. The assessments of resident #033's post fall were not consistent with each other, in relation to whether an injury was sustained as a result of a fall. (528) [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #104's SDM voiced concerns regarding the home not allowing them to fully participate in the resident's plan of care. On an identified date in January 2017, resident #104 was experiencing new symptoms. The SDM came into the home on an identified date January 2017 and was informed at this time that the resident was experiencing new symptoms. The SDM was upset they were not notified until two days after when the resident began experiencing these symptoms. The resident was assessed and the home called the physician on an identified date in January 2017. The physician ordered an intervention and the home did not notify the SDM about the intervention until one day later when the SDM called the home. Interview with staff #102 confirmed the SDM had not been given the opportunity to participate fully in the development and implementation

of the resident's plan of care. (506)
B. Review of resident #133's clinical record revealed that on an identified date in October 2016, they experienced a fall that resulted in no injury. The resident's SDM was not notified until the next day. Interview with RN #141 confirmed that the SDM should have been notified at the time of the fall and not the following day. (585) [s. 6. (5)]

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

A. On an identified date in May 2017, at a specified time, RPN #106 was observed administering medications to resident #054 while seated at their dining room table. Review of the eMAR identified that the registered staff was also to offer the resident an intervention with each medication pass. Interview with RPN #106 confirmed they had forgotten to provide the resident with the intervention at the medication pass, as required in their plan of care. (528)
B. In September 2015, resident #129 was admitted to the home with a diagnosis and was taking medications twice a day as scheduled, as well as, as needed medication. The written care plan directed staff to notify physician if the medication is used more than three times in one week. For 10 dates in October 2015, progress note documents the resident had symptoms and interventions only effective for short period of time. Review of the eMARS revealed that the resident received additional medications as needed eleven times (more than three times in one week). Progress notes confirmed that family expressed concerns regarding resident's symptoms and the following day the physician was notified and made changes to plan of care. Review of the plan of care did not include notification of the physician when the resident complained of unrelieved symptoms or when the resident required more than three 'as needed' medications in one week. Interview with RN #118 confirmed that the physician was not notified as required in the resident's plan of care. (528)
C. Resident #128 was noted to have a history of recurrent infections and the plan of care included for staff to assess, record and report signs and symptoms of the infection.
i. Responsive behaviours were noted to have increased on identified dates in February 2016 and DOS (Dementia Observation Screening) charting was initiated. Staff continued the charting and reported that the resident was displaying responsive behaviours. Progress notes indicated that staff attempted an intervention but were unsuccessful on an identified date in April 2016. On an identified date in April 2016, a different intervention was trialled. Interview with the ADOC on an identified date in June 2017, confirmed that care set out in the plan of care was not provided to the resident in that signs and symptoms were not monitored and the interventions were not completed in a

timely fashion.
ii. Family reported on an identified date in November 2016, that the resident was displaying signs and symptoms of their recurrent infection. On an identified date in November 2016, it was noted that the resident was positive for their recurrent infection and the order for the medication was not received until three days later. Interview with the ADOC on an identified date in June 2017, confirmed that care set out in the plan of care was not provided to the resident in that signs and symptoms were not monitored and the interventions were not completed in a timely manner. (156)

This non compliance was issued as a WN as the home currently has an existing compliance order for s. 6. (7) from report 2017_587129_0002 order #001 with a compliance date of July 14, 2017. [s. 6. (7)]

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

A. In September 2015, resident #129 was admitted to the home with an advance health care directive that stated "Level 2" Comfort measures with additional treatment available at the facility. On an identified date in December 2015, RPN #132 documented that resident #0129 had a change in condition. An intervention was applied, with little effect an hour later. Two hours later, the RPN documented a decline in status. The physician came in to assess resident approximately nine hours later, at which time, recommended a transfer to hospital for further assessments. The resident deceased in hospital. Review of the plan of care and interviews with RPN #132, RN #110 and #114 confirmed that the physician was not notified when the resident's condition changed and the plan of care was not reviewed and revised and interventions were unsuccessful and staff failed to notify the physician when the resident's status declined. (528)
B. Resident #128 had a history of recurrent infection and was demonstrating signs and symptoms of the infection. The physician was not notified of the results of the test until five days later when treatment was ordered. Interview with the ADOC on an identified date in June 2017, confirmed that the physician should have been notified when the results were obtained and the resident should have received treatment sooner than five days after the results were received. The resident's plan of care was not reviewed and revised when the resident's care needs changed. (156)

This non compliance was issued as a WN as the home currently has an existing compliance order for s. 6. (10)(b) from report 2017_587129_0002 order #002 with a

compliance date of July 14, 2017. [s. 6. (10) (b)]

7. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed when the care set out in plan has not been effective.

i.On an identified date in December 2016, resident #123 was complaining of feeling unwell. The next day the resident complained of still feeling unwell with several symptoms and the registered staff completed an assessment with positive findings and continued to monitor the resident and the resident was given medications.
The resident continued to present with symptoms of feeling unwell and over the course of the next four days when the resident's condition declined and the resident was sent to the hospital for assessment. Interview with RN#114 confirmed that the physician should have been informed when the resident's health status declined prior to the transfer to hospital and confirmed that the resident should have been reassessed as the care set out in the plan had not been effective. [s. 6. (10) (c)

Additional Required Actions:

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

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 there is a written plan of care for each resident that sets out the planned care for residents, that the plan provides clear directions and to ensure the SDM's are given the opportunity to participate fully in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning

devices or techniques when assisting residents.

A. An assessment from March 2017, identified that resident #033 required one person physical assistance with all transfers and their care plan directed staff to provide one person extensive assistance with all transfers.
On an identified date in May 2017, resident #033 fell during a transfer, resulting in an injury. Interview with PSW #129 confirmed that a specified PSW was with the resident at the time of the transfer and PSW #129 did not get to the room until the resident had already fallen. Interview with the specified PSW identified that they assisted the resident while the resident attempted to transfer and the resident fell. Interview with registered staff #106 confirmed staff did not use safe transferring techniques when a non certified PSW transferred resident #033 unsupervised. (528)
B. The home's policy "Safe Handling and Assessing Residents", last revised May 2017, directed staff to use a two person belt transfer if the resident could weight bear and was over 150 pounds.
On an identified date in March 2017, a Safe Lift and Transfer Assessment for resident #134 identified that the resident was able to weight bear, had unpredictable responsive behaviour and required one person physical assistance.
i. Review of the written care plan identified that the resident required one to two person extensive assistance.
ii. Review of POC documentation from March 2017, and interview with PSW #142 and RPN #124 confirmed that staff were using one person to transfer the resident as outlined in the plan of care.
Interview with RN #114 confirmed that the transfer status of the resident did not reflect the safety transfer assessment requirements in the home's policy.
iii. Interview with PSW #128, PSW #142, PSW #144, the physiotherapist and RN #114 confirmed that the policy did not reflect all of the transfers staff were using in the home. The policy referred only to a one person or two person belt transfer, if the resident was not independent or requiring a lift; and did not include the current practice of one or two person pivot transfers without the use of a belt. (528) [s. 36.]

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

Review of resident #052's plan of care identified that they required two staff extensive assistance. On an identified date in April 2017, a Safe Lift and Transfers assessment also identified that the resident required two person physical assistance for transfers.

On an identified date in June 2017, Inspector #585 observed a transfer status logo in the resident's room that identified the resident required two staff assistance for transferring. Inspector #528 observed PSW #139 transport resident #052 into their room and stated they were going to assist them. Interview with PSW #139 after they transferred the resident confirmed that they assisted the resident and that the resident required one to two person assistance. Review of documentation completed by PSW staff for the month of June 2017, identified the resident received one staff assistance for transfers 15 out of 47 times during the review period.
Interview with RPN #119 who reported to Inspector #585 that the resident required two staff assistance for transfers and that they were unaware staff provided one person assistance for transfers.

This non compliance was issued as a WN as the home currently has an existing compliance order for r.36. from report 2017_587129_0002 order #007 with a compliance date of July 14, 2017. [s. 36.]

Additional Required Actions:

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the license was subject. The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in
resident's condition, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.

For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.

The licensee did not comply with the conditions to which the license was subject.

The following residents had incomplete or late Assessment Protocols (APs) completed:

i. Resident #046 had an assessment completed with an ARD of an identified date in January 2017, however AP's related to continence care were not completed until March 2017.
ii. Resident #104 had an assessment completed with an ARD of an identified date in January 2017, however the AP's related to visual function were not completed until February 2017.
Registered staff #122 confirmed that a schedule for completing assessments was developed but at this time they did not meet the practice requirements of the RAI-MDS system.

This non compliance was issued as a WN as the home currently has an existing compliance order for s.101.(4) from report 2017_587129_0002 order #005 with a compliance date of July 14, 2017. [s. 101. (4)]

Additional Required Actions:

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Health Canada approved two documents identified as Guidance Documents and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used. These two documents are identified as:
1.Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings developed by the Hospital Bed Safety Work group, dated April 2003.
2. Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards based on the US FDA Guidance Document entitled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Work group and adopted by Health Canada in 2006.

It was identified during stage one of the Resident Quality Inspection the home had twenty six residents in the home whose bed rails had been changed to quarter length rails. All of these residents had not been assessed and their bed system evaluated in accordance with evidence-based practices to minimize risk to the resident as confirmed with the Maintenance Manager on an identified date in June 2017. [s. 15. (1) (a)]

2. The licensee failed to ensure where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

It was identified during stage one of the Resident Quality Inspection the home completed a bed rail entrapment audit in May 2017 and subsequently changed some of the bed rails from half to quarter length. Twenty six beds in the home where the rails were changed had not been re-tested to prevent entrapment, taking into consideration all potential zones of entrapment as confirmed with the Maintenance Manager on an identified date in June 2017. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where bed rails are used all residents are assessed and evaluated in accordance with evidence-based practices and to ensure where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. Resident #046's plan of care stated they required extensive assistance with oral care. Review of POC documentation completed by PSW staff for the time period during identified dates in May to an identified date in June 2017, indicated the resident received oral care twice per day for 12 days only. The home's policy for oral care indicates that oral care should be performed at least twice daily. In an interview with the resident they confirmed the staff are completing oral care twice daily
Interview with RPN #135 who reported the home's expectation was for staff to document twice a day regarding oral care and confirmed it was not completed as required for resident #046. (506)
B. Resident #132's plan of care stated they required extensive assistance with oral care and to assist with brushing teeth four times daily. Review of Point of Care (POC) documentation completed by PSW staff between identified dates in March to identified dates in April 2016, indicated the resident received oral care one to two times per day. Interview with PSW #129 confirmed the resident's plan of care indicated the resident was to receive oral care four times daily. Interview with RPN #124 who reported the home's expectation was for staff to document four times per day regarding oral care and confirmed it was not completed as required for resident #132. (585)
C. The plan of care for resident #124 identified that the resident had multiple co-morbidities. The plan of care directed registered staff to check the resident's levels twice a day. Review of the electronic medication administration record (eTAR) from February to April 2017, identified that the second daily check was not documented approximately 32 times. Interview with RPN #124 confirmed that the resident required their levels to be checked twice a day; however, it was not consistently documented in the eTARS.
D. Review of resident #133's clinical record revealed that staff were to complete and document the following: 15 minute safety checks.
On an identified date in December 2016, resident #133 experienced a fall. The resident's clinical record revealed that staff were to complete and document the following: 15 minute safety checks and the documentation was not completed.
Interview with PSW #147 reported safety interventions for the resident included: 15 minute safety checks. Interview with RN #141 who reported the resident's safety interventions were implemented; however, confirmed staff did not consistently complete documentation as required. (585) [s. 30. (2)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of the Personal Assisted Safety Device (PASD) was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

A. An observation by the Inspector on an identified date in May 2017, resident #082 used a medical device. Review of the clinical record indicated that the resident used both devices for mobility. A review of resident #082 clinical record indicated that the resident or their SDM did not provide consent for the use of the medical device as a PASD. Staff #117 confirmed on an identified date in June 2017, there was no verbal or signed consent from the resident or their SDM for the use of medical device as PASD.
B. Resident #079 was observed throughout the inspection to have used a medical device. The plan of care for this resident indicated that the resident used the medical device as a PASD to aid in mobility and positioning. On an identified date in May 2017, registered staff #108 confirmed that consent had not been obtained for the use of the PASDs. (156)
C. Resident #084 was observed throughout the inspection to have used a medical device. The plan of care for this resident indicated that the resident used the medical device as a PASD to aid in mobility and positioning. On an identified date in May 2017, registered staff #107 confirmed that consent had not been obtained for the use of the PASDs. (156) [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of PASDs were consented to by the resident or the resident's SDM, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that all the persons hired on or after January 1, 2016 as personal support workers or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements listed below and has provided the licensee with proof of graduation issued by the education provider.

During the course of the inspection, it was identified that the home used an Agency. An agreement dated December 2016, identified that for one year, the agency was to provide staff to the home. From an identified date in January 2017, agency staffing schedules were reviewed and identified thirty eight times that PSW staff worked in the home from the agency. Interview with PSW #125 confirmed they were employed by the agency. They identified that they had begun working in the home in 2017, had worked two shifts in May 2017, were enrolled in their Personal Support Worker certification course; however, had not yet completed the course. Interview with PSW #126 confirmed that they had been working for the agency for two months and started working in the home on an identified date in April 2017, without Personal Support Worker certification. Interview with registered staff #102 confirmed that both PSW #125 and #126 had worked in the home in the role of a PSW and interview with the DOC revealed they were unaware that the agency employed staff without PSW certification, as this was against the signed agreement. (528) [s. 47. (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 persons hired on or after January 1, 2016 as PSWs have successfully completed a personal support worker program that meets the requirements with proof of graduation, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On an identified date in December 2016, resident #133 experienced a fall. The resident sustained an injury and was transferred to hospital and required treatment. Review of the resident's clinical record revealed that no post-fall assessment was conducted, including a falls Risk Management report and a Falls Risk Assessment. RN #141 confirmed that no post-fall assessment was conducted when resident #133 experienced a fall that resulted in injury. (585) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home completes a post fall assessment using a clinically appropriate assessment instrument designed for falls, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

Review of the resident #132's clinical record revealed they had two areas of altered skin integrity in 2012.
i) On an identified date in July 2012, a weekly wound assessment was conducted and noted a wound. The clinical record did not indicate further assessments or notation on the status of the wound.
ii) On an identified date in July 2012, a weekly wound assessment was conducted and noted one pressure ulcer on an identified area, with no size description.
Interview with RPN #118 reported the wound healed in approximately three weeks; however, confirmed weekly assessments were not completed as required for both wounds. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #052 was admitted to the home in March 2013. Review of their plan of care identified they experienced incontinence. Review of their clinical record revealed they had not received a Bowel and Bladder Continence Assessment, which was the home's assessment instrument that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.
Interview with RPN #119 who reported the resident experienced incontinence and confirmed a Bowel and Bladder Continence Assessment had not been completed since admission. [s. 51. (2) (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 to ensure the residents receive a continence assessment using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council or Family Council was sought out when developing and carrying out the annual satisfaction survey, and in acting on its results.

Interview with the Resident's Council President on an identified date in June 2017, and a review of the Resident Council meeting minutes revealed that the council were not given the opportunity to participate in developing the home's satisfaction survey. This was confirmed by the Administrator on an identified date in June 2017. [s. 85. (3)]

2. The licensee failed to ensure that the licensee sought the advice of the Family Council in developing and carrying out the satisfaction survey, and acting on its results.

Review of the Family Council meeting minutes revealed no documentation to support that the licensee sought advice of the Family Council in developing and carrying out the satisfaction survey, and acting on its results.
Interview with the Social Service Worker confirmed the licensee had not sought the advice of Family Council in developing and carrying out the annual satisfaction survey, and acting on its results since 2014. (585) [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home seeks the advice of the Residents' and Family Council when developing the annual satisfaction survey, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee failed to that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

The home's "Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes", last reviewed May 2017, directed staff that every written or verbal complaint made to a staff member shall assist the family member to complete 'Suggestions Concerns and Complaint Form', which is then forwarded to the Administrator. The complaint and concern shall be investigated and resolved where possible.

A. A progress note from December 2016, documented that the substitute decision maker (SDM) of resident #033 had concerns related to the medications that the resident was receiving and was requesting a review of all medications. Review of the plan of care and the home's complaints log from 2016 and 2017 did not include any further action related to the SDM's concerns until they told RPN #118 of their concerns in May 2017, at which time, the physician reviewed medications. Interview with RPN #118 confirmed that the initial medication concerns in December 2016, were not followed up on until five months later. [s. 101. (1)]

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

(f) any response made in turn by the complainant.

A. A progress note from March 2017, identified that resident #033 expressed concerns to the Social Worker related to care concerns which were then communicated to the DOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns.
Interview with the Social Worker confirmed that the resident had concerns about communication with staff and their roommate, which was investigated and resolved; but was not included in the 2017 complaints log, as required. (528)
B. An interview with resident #104's substitute decision maker (SDM) identified that they came forward with a complaint/concern to the home regarding care of a resident in February of 2017. Review of the home's complaints logs for 2017 did not identify this complaint or concern. In an interview with the DOC on an identified date in June 2017, it was confirmed that RPN#119 sent an email to the DOC regarding the complaint/concern from the SDM and this complaint and concern had not been added to the complaints log. The email identified the complaint/concern and the date of the incident and who was involved in the incident, however it did not include time frames for actions taken or the final resolution for the complaint/concern, nor dates on which a response was made to the complainant. This information was confirmed with RN#138. (506)
C. Email correspondence expressing care concerns related to falls and continence care for resident #134, dated April 2017, was sent by the SDM of resident #134 to the DOC. Review of the 2017 Complaints and Concerns log did not include any documentation of the SDM's concerns. Interview with RPN #124, RN #114, and the DOC as well as review of the progress notes included a detailed response provided to the SDM; however, it was not documented in the complaints and concerns log. Interview with the DOC confirmed that the concerns from April 2017, related to resident #134 were not documented in the 2017 complaints and concerns log, as required. (528)
D. In addition, on an identified date in April 2017, an email was received by the home related to resident #134's account. Responses were provided to the family of the resident on an identified date May 2017, correspondence was sent out via mail dated a specified date in May 2017, along with, action taken on an identified date in June 2017, to address the outstanding issue. Review of the 2017 Complaints and Concern Log did not include any documentation of the concerns or action taken by the home. Interview with the DOC confirmed that the concerns were not documented in the 2017 Complaints and Concern Log. (528) [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all complaints made to the licensee concerning the care of a resident or the operation of the home are dealt with and that a documented record is kept in the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after a missing or unaccounted for controlled substance, followed by the report required under subsection (4).

A. On an identified date in January 2017 and an identified date in February 2017, registered staff were unable to locate a medication for resident #091. Interview with RPN #136 confirmed that the MD was notified; however, the incident was not reported to the Director until nine days later after the first incident. Interview with the ADOC confirmed that the incident of a missing controlled substance was not reported as required. (528) [s. 107. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is informed no later than one business day after a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

In September 2015, resident #129 was admitted to the home with a diagnosis and was taking medications twice a day, as well as, medications as needed. The written care plan directed staff to notify physician if PRN medication is used more than three times in one week. For nine dates in October 2015, the progress note documents the resident had symptoms and interventions only effective for short period of time. Family expressed concerns with the medications controlling the resident's symptoms and the following day the physician was notified and made changes to plan of care. Review of the plan of care did not include a comprehensive assessment of the resident's unrelieved symptoms and did not include notification of the physician until nine days later. Interview with RN #114 confirmed that a comprehensive assessment was not completed when the resident's symptoms were not relieved in October 2015. [s. 52. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the screening measures outlined in subsection 75 (1), shall include criminal reference checks, unless the person being screened is under 18 years of age.

Review of the home's staffing plan dated February 2017, identified that they used nursing agency staff in the event that scheduled, part time, casual, and full time RPN or PSW staff were unable to work, approximately 30 times from January to May 2017.
An agreement dated December 2016, identified that an agency would provide staffing recruitment in the home until December 2017.
Interview with the ADOC confirmed that the home did not keep screening measures for agency staff, and trusted that the agency collected all necessary documents outlined in the agency agreement. (528) [s. 75. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

Review of medication incidents from March to May 2017, and interviews with RN #114 and DOC confirmed that the home reviews each medication incident after the occurrence and corrective action is taken, as required. RPN #114 also identified that at the Professional Advisory Committee (PAC) , quarterly meetings, medication incidents are analyzed. Review of PAC minutes from January 2017 and pharmacy reports from April 2017 did not include a written record of the quarterly analysis and subsequent actions taken. Interview with the DOC confirmed that the quarterly analysis of medication incidents were not captured in the PAC meeting minutes provided and not documented as required. (528) [s. 135. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

The following were observed:
i. On an identified date in May 2017, several unlabelled and used combs, a brush and nail clippers, were found in the spa room on the Orchard home area.
ii.On an identified date in May 2017, a used and unlabelled deodorant was found in the spa room on the Falls home area.
iii.On an identified date in May 2017, a used and unlabelled brush with hair in it was found in the spa room on the Lundys home area.
The DOC confirmed that all personal items are to be labelled. [s. 229. (4)]

Issued on this 19th day of July, 2017

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

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

Ministére 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

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) :	LESLEY EDWARDS (506), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_555506_0012
Log No. / Registre no:	009915-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 7, 2017
Licensee / Titulaire de permis :	BELLA SENIOR CARE RESIDENCES INC. 1000 FINCH AVENUE WEST, SUITE901, TORONTO, ON, M3J-2V5
LTC Home / Foyer de SLD :	BELLA SENIOR CARE RESIDENCES INC. 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Bausch

To BELLA SENIOR CARE RESIDENCES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1. The licensee shall review and where necessary revise the following policies: Preventative Skin Care Program, Feeding and Hydration Policy, Safe Handling and Assessing Policy, Disposal of Medication (Poured or Wasted) and Opioid Patch Disposal.

2. The licensee shall provide training to all staff responsible for complying with the directions contained in the above noted policies. Attendance records will need to be maintained related to this training.

3. The licensee will develop and implement a system for monitoring staff's compliance with the directions contained in the above noted policy/procedure documents.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (2), scope (2) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of the potential for actual harm for the identified residents, the scope of pattern of incidents and the licensee's history of non-compliance that included: written notification (WN) issued March and August 2016 and voluntary plans of corrective action (VPC) issued in February, May, June and November 2016 and a compliance order (CO) issued in May 2017.

The licensee failed to ensure that where the Act or this Regulation requires, any

plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) requires every licensee of a long term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and 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 policy Preventative Skin Care Program found in the Resident Services Manual revised October 2013 outlined the roles and responsibilities of team members. Health care aide/Personal Support Worker: reports abnormal or unusual skin conditions to the registered nursing staff , ie: red open areas, blisters, bruises, tears, scratches.

Resident #079 was observed by Inspector #585 to have areas of altered skin integrity on two areas identified in May 2017. A review of the clinical record for the resident, under the Point of Care (POC) tasks where the PSW's document care being performed, skin observations were noted to be completed on identified shifts in May and June 2017, with no skin concerns identified. PSW staff #109 was interviewed on an identified date in May 2017 and reported that a head to toe assessment was completed on a daily basis and also on all bath days. Registered staff reported that they were not aware of the areas of altered skin integrity on an identified date in May 2017, after the inspector brought it up to the PSW. The staff confirmed that the areas of altered skin integrity had not been reported to the registered staff as per policy.
(156)

2. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, r. 68 (2)(a), the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services.

The home's "Feeding and Hydration Program - Subsection 4.9.1", revised June 2015, outlined the following direction related to monitoring and evaluating fluid intake of residents:

"If the resident has not met their fluid needs for the day, Registered Staff must assess the resident for signs and symptoms of dehydration and document the results of the assessment in the resident's clinical record. If the resident's fluid intake is below their fluid needs for three consecutive days, the resident will be placed on Fluid Watch. A Dietary Referral is to be sent to the FSM/RD to communicate that the Fluid Watch has been stated and the FSM/RD will update the care plan."

i) Review of resident #133's plan of care indicated they had a specified fluid goal per day. Review of their fluid intake report from identified dates in January 2017, revealed they had not achieved their fluid goal for four consecutive days. Their plan of care identified refer to RD if intake was less than the specified amount for three consecutive days.
Review of progress notes did not indicate the resident was placed on a fluid watch nor was documentation completed to demonstrate the resident had been assessed for signs or symptoms of dehydration.
ii) Review of resident #088's plan of care indicated they had a specified fluid goal per day. Review of the resident's fluid intake records for identified dates in June 2017,revealed they did not meet their fluid goal. Their plan of care identified refer to RD if intake less than a specified amount for three consecutive days.
Review of progress notes did not indicate the resident was placed on a fluid watch nor was documentation completed to demonstrate the resident had been assessed for signs or symptoms of dehydration. Progress notes did not include notation of signs and symptoms of dehydration.
RPN #132 reported the home's process for monitoring hydration was to refer to the Registered Dietitian (RD) when fluid intake was less than the required amount, and to implement a "Sip and Go" program. RD #149 reported they included in each resident's plan of care to notify RD if less than a specified amount of fluid was consumed for three consecutive days; however, stated it was a general statement and not an individualized intervention. RD #149 and RPN #132 confirmed the home did not implement or follow what was directed in their Feeding and Hydration Program. (585)

3. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy for 'Safe Handling and Assessing Residents', revised May 2017, defined acceptable transfers as follows:

i. Independent: this resident does not need physical aid rising from seated. Some verbal cuing and supervision may be necessary.
ii. One-Person Belt Transfer: This resident is full weight bearing, weighs 150lbs or less and needs assistance rising from a seated position.
iii. Two-Person Belt Transfer: This resident is full weight bearing, weighs greater than 150lbs and needs assistance rising from a seated position.
iv. Sit/Stand Mechanical Lift: This resident is partially weight bearing, can sit independently (to a certain degree) can follow instructions, and is behaviourally consistent
v. Total Mechanical Lift: This resident is non-weight bearing or otherwise unsuitable for the sit/stand lift.

A. An assessment from an identified date in March 2017, identified that resident #033 required one person physical assistance with all transfers and their care plan directed staff to provide one person extensive assistance with all transfers. Interview with PSW #129 confirmed that the resident required one person assistance with transferring and that they did not use a belt to transfer the resident. Interview with the PSW #128, PSW #142, PSW #144 and RN #114 confirmed that the staff are not routinely using transfers belts when transferring the residents. Interview with the Physiotherapist and ADOC confirmed that the policy had been reviewed in May 2017, but did not reflect the current practice in the home of assisting residents to transfer safely with one and two person assistance without using transferring belts. (528)
B. On an identified date in March 2017, a Safe Lift and Transfer Assessment for resident #134 identified that the resident was able to weight bear, had responsive behaviours, a history of falls and required one person physical assistance.
i. Review of the written care plan identified that the resident required one to two person extensive assistance.
ii. Review of POC documentation from an identified date in March 2017, and interview with PSW #142 and RPN #124 confirmed that staff were using one person to transfer the resident without a transfer belt as outlined in the plan of care.
Interview with RN #114 confirmed that the transfer status of the resident did not reflect the safe transfer assessment requirements in the home's policy. (585)

4. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 section 136 subsection (2) identified that the drug destruction and disposal policy must provide for drugs that were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy "Disposal of Medication (Poured or Wasted)", undated, directed staff that two registered staff were to sign for the disposal of narcotic or controlled drug on the Controlled Drug Administration Sheet.

On an identified date in December 2016, registered staff administered medications to a resident, and failed to properly account for the wasting of the controlled substance.
The medications were charted on the narcotic sheet as being wasted. Review of the Controlled Narcotic sheet did not include a second registered staff signature. Interview with RN #114 confirmed that the registered staff did not follow the home's drug disposal policy, when they did not get a second registered staff to witness and sign for the wasted controlled substances. (528)

5. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. Ontario Regulation 79/10 section 136 subsection 2 outlined that the drug destruction and disposal policy must provide for any controlled substance that was to be destroyed and disposed of was to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The home's procedure for opioid patch disposal included the use of the 'NH Opioid Patch Disposal Form' which directed staff to completed the following:
- affix used patch form the resident on this sheet in the numbered square - you may wish to use tape to ensure it is fixed
-store used sheets in a safe double locked area with other narcotics
-all sheets contain room for a maximum of five patches
-carefully remove the used patch from the resident
-carefully place the used patch in the appropriate square under the residents page for opioid disposal
-ensure that you initial and date the square that the used patch is placed on

-once the page is full ensure that it is placed with controlled substances for destruction by pharmacy
-avoid any direct contact with any patch
-do not return filled pages to pharmacy as these patches must be destroyed on site

On an identified date in April 2017, registered staff did not follow the home's procedure for removing patches from resident #024. Interview with RN #114 and RPN #136 confirmed that staff did not follow the home's patch disposal procedure. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 11, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

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

Issued on this 7th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

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