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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Jan 26, 2016	2015_341583_0021	034573-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

DOUGLAS H. RAPELJE LODGE
277 PLYMOUTH ROAD WELLAND ON L3B 6E3

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

KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)

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): December 14, 15, 16, 17, 18, 21, 22, 2015 and January 4, 5, 6 and 7, 2016.

Please note: The following inspections were conducted simultaneously with this RQI:
Complaint inspection 009697-14 related to insufficient staffing.
Critical Incident System inspection 009434-14 related to alleged staff to resident abuse; 003840-15 related to alleged staff to resident abuse; 008063-15 related to alleged staff to resident abuse; 016536-15 related to a fall where the resident was taken to hospital and that resulted in a significant change in the resident's health condition; 027667-15 alleged visitor to resident abuse and 31312-15 related to a fall where the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Resident Care, Dietary and Environmental Services Manager, Programs Manager, Clinical Documentation and Information Coordinator, registered staff, Personal Support Workers (PSW), President of Residents' Council, family representative of the Family Council, resident's and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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 sets out clear directions to staff and others who provide direct care to the resident.

A) A review of resident #400's plan of care identified they had a fall on a specified date in November 2015, that resulted in an injury and a transfer to hospital. When resident

#400 returned from hospital on a specified date in November 2015, it was identified they had an injury and required the use of a special treatment. Original physician's orders and the resident's special treatment care plan documented on a specified date in November 2015, provided different recommendations for the specialized treatment.

In an interview with the Administrator on January 7, 2016, it was shared that the home's intervention was to leave resident #400's special treatment in place at all times. Inspector #583 reviewed resident #400's special treatment care plan with the Administrator and showed the care plan provided unclear direction to direct care staff related to the application of the resident's special treatment. (583)

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 031312-15, conducted concurrently during this Resident Quality Inspection.

B) Resident #001's plan of care did not provide clear directions to staff who provided direct care to the resident in relation to skin protection. Resident #001 was observed on a specified date in December 2015, to be sitting in a wheelchair, with a special intervention in place. Clinical documentation indicated the resident had a pressure wound and wound assessments completed by registered staff indicated a special intervention was being used for this resident.

Registered staff #006 confirmed that the resident's plan of care did not provide clear directions to staff regarding the use of the special intervention when the care plan and the point of care computerized kardex did not include directions for staff providing direct care in relation to the use and application of the special treatment as an intervention to assist in managing this residents wound. (129) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident's needs and preferences.

A review of resident #012's Resident Assessment Protocol (RAP) on a specified date in November 2015, under section N – Activity Pursuit Patterns, indicated that the resident enjoyed listening to music and that they had music on their own electronic device, which staff were to give to the resident daily. A review of the resident's most recent plan of care under the recreation focus indicated that this information was not on the plan.

The resident's plan of care indicated that the resident's substitute decision maker would visit weekly and would assist the resident to and from special event programs.

It was confirmed by the Programs Manager on December 21, 2015, that the resident's plan of care was not based on the assessment of the resident's needs and preferences [s. 6. (2)]

3. The licensee has 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.

A review of the resident's most recent written plan of care indicated that resident #012 was bathed using a special intervention, due to a skin breakdown. A review of the resident's clinical record indicated that the resident's wound had healed in September, 2015.

Further review of the resident's clinical record indicated that during a Responsive Behaviour meeting in August, 2014, staff had indicated that staff could not complete the resident's shower due to the resident's size.

An interview with the ADOC on December 22, 2015, indicated that the resident was not showered due to responsive behaviours and that the special bathing intervention had been implemented due to these responsive behaviours. This was confirmed by front line staff and the Minimum Data Set (MDS) coding.

It was confirmed by the ADOC on December 22, 2015, that staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care so that the aspects of care were integrated.

An assessment completed in the plan of care in November 2015, by Behavioural Supports Ontario (BSO) and the Psychogeriatric Resource Consultant (PRC) identified a special plan would be implemented for resident #004 on a specified date in November 2015. The intervention was put in place to help manage the resident's responsive behavior. The special plan directions and documentation log were located on paper at the nursing station and were not included in the behavior care plan, Point of Care (POC)

or resident #004's clinical record. A review of the log showed that a documented record was kept until a specified date in November 2015. A review of the plan of care identified the intervention had not been discontinued by the BSO/PRC team and it was documented that resident #004 had demonstrated responsive behaviours six times in a two week period. In an interview with the DOC on January 7, 2015, it was confirmed that the special intervention was not in place at the time of the interview. [s. 6. (4) (b)]

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

A) Resident #012 had a restraint and a device on their wheelchair to assist with positioning. A review of the resident's most recent plan of care indicated that staff were to check the resident to ensure that the Personal Assistance Service Device (PASD) was in the proper position, the resident was safe and the PASD had been released every two hours. In addition the resident's most recent plan of care directed staff to change and or check the resident's incontinent product routinely "before and or after meals, before bed and when necessary".

On a specified date in December 2015, resident #012 was observed by Long Term Care Home's (LTC) Inspector #508 from 1020 hours to 1400 hours. During this time the staff had not checked the resident's brief or removed the PASD's. It was confirmed through observation of the resident on a specified date in December 2015, that the care set out in the plan of care was not provided to the resident as specified in the plan. (508)

B) Resident #006 was observed up in their wheel chair on a two specified date in December 2015, wearing a night gown. In an interview with Personal Support Worker (PSW) #011 it was shared that staff had been dressing resident #006 in only night gowns for approximately one year. A review of the dressing care plan identified that resident #006 required assistance with dressing and was to be dressed appropriately using adaptive clothing. In an interview with the Director of Care on December 18, 2015, it was confirmed that resident #006 had adaptive clothing available in their closet and that care was not provided to the resident as specified in the dressing care plan. (583)

C) In an interview with resident #004 on a specified date in December 2015, they shared they refused the shower that they were offered that morning. A review of resident #004's responsive behaviours care plan identified staff were to keep a bath refusal log. The intervention directed two staff to sign a log with resident #004 present when the resident refused to have a bath. In an interview with registered nursing staff #009 on December

18, 2015, it was confirmed that there was no paper or electronic documentation of the bath refusal log. Registered nursing staff #009 confirmed with the PSW's the bath log intervention was not being completed as specified in the plan of care. (583)

D) A review of the plan of care for resident #012 indicated that due to responsive behaviours, the resident's showers were discontinued and staff were to bathe the resident with a special product.

During an observation of the resident's room, it was identified by LTC Inspector #508 that a scented body wash was on the resident's bedside table. It was confirmed by front line staff who provide care to resident #012 that this was the soap that was used to bathe the resident, not the special product as indicated in the resident's plan of care. It was confirmed by the ADOC during an interview on December 22, 2015, that the care set out in the plan of care was not provided to the resident as specified in the plan. (508)

E) Resident #010 was not provided with care as set out in the plan of care when staff did not release the device on the resident's wheelchair every two hours and did not turn and reposition the resident in accordance with the schedule identified in the Point of Care (POC). The resident's plan of care specified that staff were to complete personal assistant service device (PASD) documentation to confirm that the device on the resident's wheelchair was released every two hours and also specified that the resident was on a turning and repositioning schedule as per the schedule in POC. Point of Care documentation reviewed over a 14 day period indicated that staff did not release the tray table and did not reposition the resident in accordance with the schedule for these activities on seven of the 14 days reviewed.

Resident #010 and observations made over a period of time in excess of two and a half hours on a specified date in December 2015, confirmed that the care specified in the resident's plan of care was not provided when staff did not remove the tray table and reposition the resident during the observation period. (129)

6. The licensee failed to ensure that the residents plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

A) A review of the Minimum Data Set (MDS) coding under section-H. - continence in the last 14 days, completed on a specified date in July 2015, indicated that the resident was continent for bowel. A review of the resident's written plan of care with a completion date

in August 2015, indicated that the resident was incontinent of bowel. It was confirmed by the Director of Care that the resident's plan of care had not been reviewed and revised when the resident's care needs changed. (508)

B) Registered staff #006 and clinical documentation confirmed that resident #001's plan of care had not been updated when the care specified related to a wound was no longer necessary. Resident #001 sustained an injury as a result of a fall and returned to the home on a specified date in August 2015 after receiving surgical intervention to repair the injury. At that time the resident's plan of care directed staff to complete a treatment to the surgical wound. Resident #001's plan of care also indicated the resident had a skin tear and the plan of care directed staff to complete a treatment as ordered to this skin tear. Registered staff #006 confirmed that at the time of this inspection the above noted directions remained in the resident's plan of care, the resident no longer had a surgical wound or a skin tear and the plan of care had not been revised.

C) Registered staff #006 and clinical documentation confirmed that resident #002's plan of care had not been updated when the care specified related to a wound was no longer necessary. It was identified by registered staff during the initial phase of this inspection and on three wound care assessments completed in December 2015, that resident #002 had a pressure wound. Staff #006 confirmed that there was a short term care plan in place for this resident that indicated a wound was present in a specified area and there were directions in the plan of care that skin protection was to be used as an intervention for the management of the wound. It was identified to registered staff #006 that the resident had been observed on a specified date in December 2015 and was not wearing skin protection for the specified area. Registered staff #006 subsequently confirmed that resident #002 no longer had a wound in the specified area, the care identified in the plan of care was no longer necessary and the plan of care had not been revised.

D) Registered staff #001 and clinical documentation confirmed that resident #010's plan of care was not reviewed or revised when the resident experienced worsening bowel continence. MDS data collected on a specified date in October 2015, indicated the resident was occasional incontinent of bowel. Data collected on the following MDS review completed on a specified date in November 2015, indicated the resident's bowel continence had worsened and the resident was identified as frequently incontinent of bowel. At the time of this inspection, the resident's plan of care had not been reviewed or revised when it was confirmed that there were no new directions to staff related to the promotion and management of the resident's worsening bowel continence. [s. 6. (10) (b)]

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

Resident #012 was identified as having responsive behaviours. Due to ongoing responsive behaviours, the resident was referred to the BSO team to assist the home's staff with managing the resident's behaviours, specifically with bathing and transferring.

In August, 2014, the resident's bi-weekly showers were discontinued and a special product used for full sponge bathing in the resident's bed was implemented to try to reduce the resident's responsive behaviours.

A review of the resident's clinical record indicated that the resident continued to demonstrate responsive behaviours after this intervention had been implemented, however; this intervention continues to be in the resident's plan of care and has not been reassessed since August, 2014, when it was initially implemented.

It was confirmed during an interview with the DOC on January 6, 2016, that the resident was not reassessed and the plan of care reviewed and revised when care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident and in the development and implementation of the plan of care so that they are integrated, consistent with and complemented each other and to ensure that the residents plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, procedure or strategy that the policy, procedure or strategy was in compliance with all applicable requirements under the Act.

A) Directions contained in the home's policy titled "Skin and Wound Care Program", identified as MPOO-OO6 with a revised date of April 28, 2015 were not in compliance with O. Reg. 79/10, s. 50(2)(b)(iv). This policy directed that weekly measurements must be taken of wounds and weekly skin assessments for completed for rash, scaly scalp and skin reddened areas. The home's skin and wound program did not specify that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds were to be reassessed weekly. The Administrator confirmed that the document provided at the time of this inspection was the only document that explained the home's skin and wound care program.

B) Directions contained in the home's policy titled "Continence Care and Bowel Management", identified as MP00-001with a revised date of December 8, 2015 were not in compliance with O. Reg. 79/10, s. 51(1) 1. Documentation of the continence care and bowel management program provided by the home included treatments and interventions related to bladder incontinence and constipation, but did not provide for treatment and interventions related to bowel incontinence. The Administrator confirmed that the document provided at the time of this inspection was the only document that explained the home's continence care and bowel management program.

C) Directions contained in the home's policy titled "Falls Prevention Program" identified as MPOO-002 with a revised date of December 15, 2015 were not in compliance with O.

Reg. 79/10, s. 49(1). Documentation of the home's falls prevention program does not provide for strategies to reduce or mitigate falls. The Administrator confirmed that the document provided at the time of this inspection was the only document that explained the home's falls prevention program. [s. 8. (1) (a)]

2. The licensee failed to ensure that where the Act or this Regulations required the licensee of a long term home to have , institute or otherwise put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

A) During a lunch observation on a specified unit on a specified date in December 2015, dietary aide #004 was observed rinsing the soiled lunch dishes in the hand washing basin located in the servery by inspector #129. The safe food handling procedure was provided by the Administrator and it was confirmed that the home followed the "Niagara Food Handler Certification Manual/Niagara Region Public Health" procedures. On page 30 of the procedure it was identified that handwashing basins were to be used for handwashing only, not for dishwashing or food preparation. In an interview with the Administrator on January 4, 2016, it was confirmed that the safe food handling procedure was not complied with. (#583)

B) Staff failed to comply with the directions contained in the home's policy titled "Skin and Wound Care Program" identified as MP00-006 with a revised date of April 28, 2015. The Administrator confirmed that it was the expectation of the home that when staff were completing the documents required in this policy that those documents would be completed accurately.

i) Registered staff #006 and clinical documentation confirmed that staff completing wound documentation for resident #001 in relation to the measurements of the resident's wound did not accurately documented in accordance with the expectations of the home. Consecutive documentation of five wound assessments in November, and four in December, 2015 indicated the wound measured to be the same specified size. Although the wound measurements documented had not changed over this period of time, staff concluded that the resident's wound was healing.

ii) Registered staff #006 and clinical documentation confirmed that staff completing wound assessments on five dates in December, 2015 did not accurately reflect the measurements of resident #001's wound when two different sets of measurements for the wound were documented.

iii) Wound assessments completed for a stage three wound to resident # 009's right foot completed on 6 dates between October and December 2015, documented progressively smaller wound measurements that indicated the resident's wound was healing. Clinical documentation indicated that on the last four assessments completed during the above noted time period staff completing the assessments concluded that the wound was not healing.

C) Staff failed to comply with directions contained in the home's policy titled "Continence Care and Bowel Management", identified as MP00-001 with a revised date of December 8, 2015.

This policy directed that an assessment will be completed after any change in condition that affects continence. The policy also identified that this assessment includes identification of causal factors, patterns, type of incontinence, potential to restore function and identification type and frequency of physical assistance necessary to facilitate toileting. Resident #010's condition changed when RIA-MDS documentation on a specified date in May, 2015 and July 2015, indicated the resident was continent of bowel, documentation on a specified date in October 2015 indicated the resident's bowel continence had changed and the resident was occasionally incontinent of bowel. Resident #010's condition deteriorated further when RIA-MDS documentation on a specified date in November 2015, indicated the resident was frequently incontinent of bowel.

Clinical documentation provided by staff in the home and discussion with the Administrator, the Director of Resident Care and staff #003 confirmed that resident #010's condition related to bowel continence had changed and that an assessment, in accordance with the directions in this policy had not completed when the resident's condition changed. [s. 8. (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 that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure that the policy and procedure are in compliance with all applicable requirements under the Act and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On a specified date in March 2015, it was reported to the Administrator that a staff member had been rough with resident #304 while assisting with care. The resident could not recall the date of this incident, however; did remember which staff member had hurt them. The Administrator documented that the resident was upset and crying when describing what had occurred.

After the home's investigation, the employee was disciplined for being rough with resident #304.

It was confirmed by the Administrator during an interview on January 5, 2016, that resident #304 was not protected from abuse by the staff in the home.

PLEASE NOTE: This non compliance was identified during a Critical Incident inspection, log #003840-15, conducted concurrently during the Resident Quality Inspection. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

On a specified date in 2015, a staff member observed a visitor in resident #303's room inappropriately touching the resident. Resident #303 was incapable of giving consent due to their diagnosis. The staff member left the resident alone with the visitor to report the incident to the registered staff on duty. When the registered staff member went to the resident's room, the visitor had left.

A review of the home's policy titled Abuse and Neglect - Zero Tolerance, index # RR00-001, directed staff who witness abuse of a resident to intervene if safe to do so, or identify interventions to ensure resident safety and well being when an incident has occurred.
The policy also directed registered staff to assess the resident from head to toe and to document the assessment in the resident's progress notes.

A review of the incident report and the resident's progress notes indicated that the staff member left the resident alone with the visitor to report the incident to registered staff. Registered staff did not do a head to toe assessment and the resident had not been assessed until four days after the incident.

It was confirmed by the Administrator during an interview on January 5, 2016, that the written policy that promoted zero tolerance of abuse and neglect of residents was not complied with.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 027667-15, conducted concurrently during this Resident Quality Inspection. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition.

Staff did not reposition resident #010, who was unable to reposition themselves over a two and a half hour period of time on a specified date in December 2015. Resident #010's plan of care indicated the resident required total assistance of two staff with a mechanical lift for all transfers and required extensive assistance with for bed mobility. The resident was monitored from 0930hrs to 1200hrs on a specified date in December 2015 and was noted to be sitting in their room in a wheelchair that had been tilted to a 45 degree angle with a tray table attached to the wheelchair during this period of time.

The resident confirmed that staff had assisted them into the wheelchair at 0600hrs and that staff had not removed the tray table or assisted them to reposition in the wheelchair since rising. The resident also confirmed that they were unable to remove the tray table attached to the wheelchair and reposition themselves. Staff #010, who was assigned to provide direct care to the resident on a specified date in December 2015, confirmed that the resident was not repositioned over the two and one half hours during which the resident was monitored. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition, to be implemented voluntarily.

WN #6: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence. O. Reg. 79/10, s. 51 (1).

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 failed to ensure that the continence care and bowel management program provided treatments and interventions to promote continence.

The Administrator provided the home's policy and procedure tilted, "Continence Care and Bowel Management", identified as #MPOO-001, with a revised date of June 7, 2013. A review of this policy confirmed that although there are treatments and interventions for urinary incontinence and constipation this policy did not provide directions for staff related to treatments and interventions for to bowel continence. [s. 51. (1) 1.]

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

Staff collecting data on the Minimum Data Set (MDS) tool completed on a specified date in October 2015, identified that resident #010 had become incontinent of bowel when coding on the tool indicated the resident was "occasionally" incontinent of bowel after being identified as continent of bowel previously. Clinical documents provided by the home that were discussed and reviewed with the Administrator, DOC, staff #003 and regional staff #013 confirmed that after it was identified on a specified date in October

2015 that resident #010 had developed occasional incontinence of bowel the resident was not assessed in order to identify causal factors, patterns, type of incontinence or the potential to restore bowel continence.

Staff collecting data on a subsequent MDS tool completed on a specified date in November 2015, identified that resident #010's bowel continence had deteriorated and the resident was now identified as "frequently" incontinent of bowel. Clinical documents provided by the home that were discussed and reviewed with the Administrator, DOC, staff #003 and regional staff #013 confirmed that after it was identified on a specified date in November 2015, that resident #010 was now identified as "frequently incontinent of bowel the resident was not assessed in order to identify causal factors, patterns, type of incontinence or the potential to restore bowel continence.

The Administrator and the DOC confirmed that the home did not have a clinically appropriate assessment instrument specifically designed for assessing bowel continence when they indicated that staff had completed a "Non-triggered Constipation Resident Assessment Protocol" in October 2015, and November 2015 and indicated this was the assessment of bowel continence. These documents provided by the home were not designed for assessing bowel continence and exclusively dealt with constipation. [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 that each resident who is incontinent receives an assessment that included the 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 requires, an assessment is conducted using a clinically appropriate assessment instrument that specifically designed for the assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was being restrained by a physical device was released from the physical device and repositioned at least once every two hours.

On a specified date in December 2015, at 1020 hours, resident #012 was observed on sitting in their tilt wheelchair with a device secured to the wheelchair. The resident also had a restraint that was observed to be fastened.

At 1045 hours, LTC Inspector #508 observed a volunteer removing resident #012 from the unit and took the resident in their wheelchair to the Chapel to attend a service.

At 1200 hours, the resident was brought into the main lounge area by a volunteer and sat with a family member who had come in to visit with the resident. At 1215 hours, the resident went for lunch with family member and stayed with the resident until 1330 hours.

During this time the resident's personal assistive service device with restraining effects had not been released and the resident had not been repositioned for three hours. [s. 110. (2) 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 residents who are being restrained by a physical device are released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee was on duty at all times.

On December 6, 2014, from 0700 - 1500 hours, and on August 8, 2015, from 2300 - 0700 hours, the registered nurses (RN's) scheduled to work these shifts had called to report that they were not able to report to work. The licensee was unable to replace these two shifts with RN's and on both occasions, registered practical nurses replaced the RN's.

It was confirmed by the Administrator on January 6, 2016, that there was not at least one RN on duty and present on December 6, 2014, and August 8, 2015.

PLEASE NOTE: This non compliance was identified during an inspection, log #009697-14, conducted concurrently during this Resident Quality Inspection. [s. 8. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's psychological well-being.

Staff #001 confirmed that resident #010's plan of care was not based on an interdisciplinary assessment of the resident's psychological well-being when on a specified date in 2015, the resident was identified as having significant depressive symptoms. Clinical documentation confirmed that in response to a referral by nursing staff, the Social Worker visited the resident on a specified date in 2015, administered the Geriatric Depression Scale (GDS). Directions for use of the GDS indicated that any positive score above five should promote an in-depth psychological assessment. Staff #001 and clinical documentation confirmed that following the administration of the GDS completed on a specified date in 2015, an interdisciplinary assessment to determine resident specific issues related to the scoring on the GDS was not completed. [s. 26. (3) 6.]

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences.

A review of the resident's plan of care indicated that the plan did not identify any religious preferences and the information in the assessment had not been included in the resident's plan.

It was confirmed by the Programs Manager on December 21, 2015, that the plan of care for resident #012 was not based on the interdisciplinary assessment of the resident's religious preferences. [s. 26. (3) 22.]

WN #10: 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 failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Resident #400 had a fall on a specified date in November 2015, which resulted in an injury and a transfer to hospital. A review of the plan of care identified resident #400 was at risk for falls and had two previous falls in June and July 2015. The post fall assessments completed for all three falls identified ambulating without assistance as a predisposing situation. The falls care plan intervention created prior to the June 2015, directed staff to check resident #400 every hour to ensure safety.

In an interview with the DOC on January 7, 2016, it was shared that a task to monitor resident #400 every hour was not found in the Point of Care electronic record. It was confirmed that there was no documentation of the hourly monitoring intervention for resident #400 for several weeks. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

A) In an interview with resident #004 on December 15, 2015, they shared they were offered and received a shower that morning but it was their preference to receive a bath. A review of the electronic Point of Care (POC) documentation identified resident #004 received a shower on two specified dates in November and one specified date in December 2015. A thirty day look back of the documentation identified resident #004 did not receive a bath for four weeks. A review of the bathing plan of care identified resident #004 required total assistance with bathing and preferred baths. In an interview with the Director of Care on December 18, 2015, it was confirmed that resident #004 was not bathed by a method of his or her choice. (583)

B) A review of resident #302's plan of care indicated that the resident preferred to have showers and the resident was to have two showers a week. The POC documentation reviewed on January 7, 2016, indicated that the resident only had a shower three times within a 30 day period and had five full body sponge bath instead of the resident's preference of a shower.

It was confirmed by documentation in the resident's clinical record and during an interview with the DOC on January 7, 2016, that resident #302 was not receiving at a minimum, a shower twice a week. (#508) [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her desired rest routines supported and individualized to promote comfort, rest and sleep.

On a specified date in December 2015, LTC Inspector #583 entered resident #300's room to complete the stage one resident quality care inspection interview at 1100 hours. At the beginning of the interview resident #300 shared they were uncomfortable in their wheel chair, were having back pain and requested to be put in bed. Long Term Care Home's (LTC)Inspector #583 rang the call bell for assistance.

Personal support worker #015 and #010 entered the room and resident #300 requested to lie down in bed. Personal support worker #010 identified the lunch meal was being served in an hour then reviewed the menu choices with resident #300. Staff exited the room. The LTC Inspector #583 proceeded with the interview at which time resident #300 showed physical signs of discomfort and verbalized they had back pain and expressed they would like to lay in bed. The LTC Inspect or #583 exited the room and notified the Director of Care that resident #300's desired rest routine was not supported or individualized to promote comfort and rest. [s. 41.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal.

Planned menu items for the lunch meal on December 17, 2015, were not offered and available to residents. Staff #004 and the home's published menu confirmed that for the lunch meal on December 17, 2015, the second selection available for residents was beef pie with gravy, herbed turnip and wheat bread. The meal service was observed and it was noted that the "show plate" being used to offer the resident choice did not accurately reflect the posted menu, when the "show plate" for the second selection of the beef pie did not contain wheat bread. During this meal it was noted that 11 residents choose the beef pie option and 11 of those 11 residents were not offered whole bread.

Staff #004 confirmed that this planned menu item was not offered to the residents who selected this option and although there was whole wheat and white bread available in the servery no residents were offered bread. Staff #004 confirmed that texture modified bread was not available for those residents who were identified as requiring a texture modified diet and requested the beef pie option. [s. 71. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menus were communicated to the residents.

During an observation of the lunch meal service on House 200 on December 14, 2015, it was observed that the seven day menu was not posted. In an interview with dietary aide #005 it was confirmed that the seven day menu was not posted on the board across from the dining room. It was shared that this was the location where the seven day menu would be communicated to residents. [s. 73. (1) 1.]

Issued on this 8th day of February, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_341583_0021
Log No. / Registre no:	034573-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 26, 2016
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	DOUGLAS H. RAPELJE LODGE 277 PLYMOUTH ROAD, WELLAND, ON, L3B-6E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brent Kerwin

To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Previous non compliance with a VPC January 24, 2013 and a WN September 14, 2015.

The licensee shall complete the following.

1. Ensure that resident #012's PASD is released and the resident is repositioned and that their incontinent product is checked as directed in their plan of care.
2. Ensure that resident #006 is dressed as per the resident or substitute decision maker wishes, that the dressing care plan reflects their choice and the resident is dressed as directed in their plan of care.
3. Ensure that resident #004's responsive behaviour interventions are provided as directed in the plan of care.
4. Ensure that resident #012's bathing care plan meets their hygiene requirements and that the bathing interventions are provided as directed in the plan of care.
5. Ensure that resident #010's tray table is released and the resident is repositioned every two hours as directed in the plan of care.

Continue ongoing monitoring including visual observation to ensure all residents are being provided care as specified in their plans.

Grounds / Motifs :

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

The licensee failed to ensure that care set out in the plan of care was provided

to the resident's as specified in the plan.

A) Resident #012 had a restraint and a device on their wheelchair to assist with positioning. A review of the resident's most recent plan of care indicated that staff were to check the resident to ensure that the Personal Assistance Service Device (PASD) was in the proper position, the resident was safe and the PASD had been released every two hours. In addition the resident's most recent plan of care directed staff to change and or check the resident's incontinent product routinely "before and or after meals, before bed and when necessary".

On a specified date in December 2015, resident #012 was observed by Long Term Care Home's (LTC) Inspector #508 from 1020 hours to 1400 hours. During this time the staff had not checked the resident's brief or removed the PASD's. It was confirmed through observation of the resident on a specified date in December 2015, that the care set out in the plan of care was not provided to the resident as specified in the plan. (508)

B) Resident #006 was observed up in their wheel chair on a two specified date in December 2015, wearing a night gown. In an interview with Personal Support Worker (PSW) #011 it was shared that staff had been dressing resident #006 in only night gowns for approximately one year. A review of the dressing care plan identified that resident #006 required assistance with dressing and was to be dressed appropriately using adaptive clothing. In an interview with the Director of Care on December 18, 2015, it was confirmed that resident #006 had adaptive clothing available in their closet and that care was not provided to the resident as specified in the dressing care plan. (583)

C) In an interview with resident #004 on a specified date in December 2015, they shared they refused the shower that they were offered that morning. A review of resident #004's responsive behaviours care plan identified staff were to keep a bath refusal log. The intervention directed two staff to sign a log with resident #004 present when the resident refused to have a bath. In an interview with registered nursing staff #009 on December 18, 2015, it was confirmed that there was no paper or electronic documentation of the bath refusal log. Registered nursing staff #009 confirmed with the PSW's the bath log intervention was not being completed as specified in the plan of care. (583)

D) A review of the plan of care for resident #012 indicated that due to responsive behaviours, the resident's showers were discontinued and staff were

to bathe the resident with a special product.

During an observation of the resident's room, it was identified by LTC Inspector #508 that a scented body wash was on the resident's bedside table. It was confirmed by front line staff who provide care to resident #012 that this was the soap that was used to bathe the resident, not the special product as indicated in the resident's plan of care. It was confirmed by the ADOC during an interview on December 22, 2015, that the care set out in the plan of care was not provided to the resident as specified in the plan. (508)

E) Resident #010 was not provided with care as set out in the plan of care when staff did not release the device on the resident's wheelchair every two hours and did not turn and reposition the resident in accordance with the schedule identified in the Point of Care (POC). The resident's plan of care specified that staff were to complete personal assistant service device (PASD) documentation to confirm that the device on the resident's wheelchair was released every two hours and also specified that the resident was on a turning and repositioning schedule as per the schedule in POC. Point of Care documentation reviewed over a 14 day period indicated that staff did not release the tray table and did not reposition the resident in accordance with the schedule for these activities on seven of the 14 days reviewed.

Resident #010 and observations made over a period of time in excess of two and a half hours on a specified date in December 2015, confirmed that the care specified in the resident's plan of care was not provided when staff did not remove the tray table and reposition the resident during the observation period. (129)
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 26th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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