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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 4, 2018	2018_525596_0003	004872-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

THERESA BERDOE-YOUNG (596), CECILIA FULTON (618), JUDITH HART (513), JULIENNE NGONLOGA (502), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, April 3, 4, 5 and 6, 2018.

Inspector Joanna White (727) attended this inspection during orientation.

The following complaint logs were inspected concurrently with the Resident Quality Inspection (RQI): log #010759-17, log #020934-17 related to resident care concerns, log #013768-17 related to resident care concerns and dining service, log #024675-17 related to administration of medications and resident care concerns, log #028026-17 related to medication management, log #028420-17 related to allegation of staff to resident abuse, log #004441-18 related to skin and wound care, continence care and medication administration.
The following critical incident (CI) reports were inspected concurrently with the RQI: log #028969-17 related to allegation of staff to resident physical abuse, log #012890-17 and log #024339-17 related to falls prevention and management and critical incident reporting, log #029331-17 related to falls prevention and management, log #023611-17 related to injury of cause unknown, log #028859-17 related to concerns with resident transferring and positioning.
A follow up inspection log #001192-18 was completed concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Director of Nursing (DON), Nurse Manager/Infection Prevention and Control Lead (NM/IPAC Lead), Nurse Manager (NM), Acting Nurse Manager (ANM), registered dietitian (RD), physiotherapist (PT), nutrition manager, registered nurse (RN), registered practical nurse (RPN), personal care assistant (PCA), Residents' Council president, Family Council chair, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2017_659189_0024	596

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. 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.

Review of a critical incident system (CIS) report submitted to the ministry of health and long term care (MOHLTC) revealed that resident #025 was found with an injury and

moaning for pain on a specified date. The resident was transferred to hospital for further assessment and diagnosed with a particular medical condition.

Review of the home's investigation revealed that on the day before the resident was discovered with the injury personal care assistants (PCA) #124 and #138 had transferred resident #025 using one identified lift, instead of another identified lift that should have been used for the resident; they were both disciplined.

Review of resident #025's written plan of care under the focus of activities of daily living (ADL) assistance, related to inability to follow instruction revealed that the resident was totally dependent on two or more person physical assistance for transfers using an identified lift. According to the plan of care the resident had cognitive impairment.

In separate interviews, PCAs #139, #138 and #124 acknowledged being aware that resident #025 required use of the identified lift indicated in the resident's written plan of care, for all transfers. They still used the wrong lift to transfer them onto the toilet, as they could stand and walk when they were in a good mood.

PCA #138 confirmed that they assisted PCA #124 on the above mentioned specified date before dinner to change resident #025's incontinence product in the spa room, using a different lift from the one specified in the resident's plan of care. PCA #138 stated that the resident was able to weight bear and hold but not able to follow directions.

PCA #124 confirmed that they used the wrong lift to change resident #025's continence product in the spa room before dinner. The PCA indicated that it was not the first time they used the wrong lift as the resident will stand for them.

The director of nursing (DON) #131 acknowledged that both PCAs did not use safe transfer techniques when assisting resident #025 with toileting. They indicated that the home's expectation was for staff to follow the resident's written plan of care. [s. 36.]

2. Review of a CIS report submitted to the MOHLTC revealed resident #026 reported that staff had injured them while they ambulated on the unit on a specified date. The resident had complained of pain to an identified body part, and swelling and a particular injury were noted on another body part.

Review of resident #026's progress notes revealed that on specified date at 2230 hours, the resident had injured them while being pushed in their wheelchair by a staff member.

The resident complained of pain to an identified body part, and swelling and a particular injury was noted on another body part. The next day the resident was not able to weight bear, was assessed by the home's physician and sent to the hospital for further assessment.

Review of a consultation report from William Osler Health System six days later indicated that the resident's identified body part was obviously deformed with a particular diagnosis, a second identified diagnosis and a particular injury. The resident's identified body part was tender and they were neurologically intact. A diagnostic test confirmed the above mentioned diagnoses.

Review of the resident's minimum data set (MDS) annual assessment dated two months earlier indicated that the resident had short and long-term memory problem, and they were moderately impaired in their ability to make decisions.

During interview PCA #144 indicated that they were wheeling the resident before breakfast from their bedroom to the dining room. The PCA stated that they stopped on the way to answer another resident's call bell. When they returned they continued to push the resident not knowing that the resident had placed their foot behind the footrest. They confirmed that they did not tilt the wheelchair when pushing the resident.

In an interview Nurse Manager (NM) #118 stated that they had discussed it with the PCA at the time of incident. NM #118 indicated the foot rest was folded up to allow the resident to ambulate independently for short distances. However, at the time of the incident PCA #144 forget to place them properly before assisting the resident to ambulate using the wheelchair.

In an interview, physiotherapist (PT) #143 stated that they assessed resident #026 three months earlier and educated the nursing staff about resident #026's specific wheelchair. According to PT #143 they told the nursing staff to ensure that the resident's feet were supported on the footrest, the wheelchair tilted to a certain degree so that the feet were not caught in between the chair. PT #143 stated resident #026's specific wheelchair was not used properly because the resident was able to place their foot on the floor while being pushed; this resulted in a change of the resident's condition and their transfer status changed from two person, to two person using an identified lift, as they were unable to walk. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction were reported to the resident, the resident's substitute decision maker, if any, and the resident's attending physician.

Review of the home's medication incident reports which had occurred in the fourth quarter, including the months of October, November and December 2017, were conducted.

During the above mentioned time frame the home had nine documented incident reports. Out of those nine incidents six of them required that the resident or their substitute decision maker (SDM), and physician both be notified.

The following medication incidents were not reported to the resident or their SDM (file name/number as provided by home): Medinc 21448, Medinc 21653, Medinc 21980, Medinc 22587, Medinc 22586.

The following medication incidents were not reported to the resident's physician: Medinc 22586, Medinc 22587, Medinc 22156.

Interview with the DON confirmed that there was no documentation to confirm if proper notification of family or in some cases physician had occurred, for the above mentioned medication incidents. The lack of documentation on the incident report forms revealed that the required notification did not occur for these medication incidents. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Record review of a CIS report indicated that the resident was transferred to hospital on a specified date in 2017, related to pain. Resident returned from hospital approximately one month later with particular diagnoses.

Record review of the resident's progress notes indicated that the resident had a history of four falls in a one month time period, and subsequently a near miss two months later. Complaints of worsening pain led to the resident's transfer to hospital the following month with diagnosis of a particular medical condition.
Record review of the physiotherapy referral and assessment of a specified date after the dates of the above mentioned four falls in one month, indicated the resident was assessed for use of a hip protector and it was ordered.

Interview with personal care assistant (PCA) # 125 and #117 revealed that the resident was high risk for falls, and the use of a particular falls prevention and management equipment daily was one of the falls interventions included in the resident's plan of care; the resident had been using it for several months.

Record review of the resident's written falls risk care plan did not include the use of the above mentioned falls prevention and management equipment.

Interview with Acting Nurse Manager (ANM) #126 and the Director of Nursing (DON) revealed that the use of the above mentioned equipment for resident #015 was not updated in the plan of care, and it was somehow missed. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A complaint was received by the MOHLTC that stated resident #027 had been hospitalized three times for a particular medical condition, that the resident's plan of care clearly indicated that the bed was to be kept at a certain angle and was found to be flat.

The complainant was not able to be reached by phone and the request by Inspector #513 for the complainant to return the call was unanswered.

A review of the progress notes revealed the resident had been on an identified diet texture for more than one year.

A review of the most recent written plan of care of a specified date in July 2017, located in the unit's care plan binder for PSW staff and others who did not have computer access, revealed the resident was to be kept upright for a specified time period to prevent a particular medical condition.

The written plan of care of a specified date in March 2018, which was located in the computer available only to registered staff and not in the care plan binder available to PSW staff, stated to keep the resident in the upright position for a different specified time period than the one mentioned above, after each meal to prevent a particular medical condition. A further review of the computer generated written plan of care revealed a plan of care created in April 2017, and last updated approximately 11 months later was not in the care plan binder.

An interview with PSW #119 revealed the written plan of care to which staff had access, did not set out clear direction for the resident’s current needs.

An interview with RN #121 revealed the written plan of care located in the unit’s care plan binder identified the resident was to be kept upright for specified time period mentioned above to prevent a particular medical condition. The current written plan of care located in the computer stated the resident was to sit in an upright position for a different specified time period after eating and drinking. In addition, the written plan of care updated in the computer in March 2018, was not located in the unit’s care plan binder for resident #027. RN #121 confirmed the written plan of care had not been updated in the unit’s care plan binder to reflect the resident’s current needs, and therefore the written plan of care did not set out clear direction for staff regarding length of time the resident was to be positioned upright after meals.

An interview with the DON confirmed all residents' written plans of care should be updated and available for staff in the care plan binder, and in this instance the written plan of care did not set out clear direction to staff and others who provide care to resident #027. [s. 6. (1) (c)]

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

This inspection was initiated to inspect issues identified in complaint intake.

Record review revealed a physician's order for a particular diagnostic test to be completed for resident #035 on a specified date 2017.

The shift communication book contained a notation, written on the above mentioned specified date in November 2017, that the diagnostic test was required for resident #035.

A nursing note written on the same day mentioned that resident was seen by physician and the power of attorney was notified of new orders. No specific mention of the diagnostic test was made in the nurses' progress notes.

Review of the communication book made no mention of whether the diagnostic test was completed until a notation made five days later stated that a particular supply was given to the resident to complete the first part of the diagnostic test.

Review of the nursing progress notes made no mention of the status of diagnostic test from the date it was ordered until eight days later, when it was documented that the first part of the diagnostic test was completed.

Interview with registered nurse (RN) #105 revealed that the information about the ongoing need to complete the first part of a diagnostic test like this one would be achieved through documenting in the communication book and in the 24 hour report, which are documented electronically; also verbally passing on this information to the oncoming shift. RN #105 revealed that if this communication was missed it may possibly not be endorsed to the next shift and could be lost.

RN #105 revealed once the test was ordered by the physician, it should occur as soon as possible. If there is difficulty completing it within a day or so, then discussion should occur about how best to get it done, with further follow up with the physician if necessary.

Interview with Nurse Manager (NM) #127, confirmed that the delay in completing the diagnostic test was not acceptable and that the first part should have occurred within a few days. [s. 6. (7)]

4. Review of a CIS report submitted to the MOHLTC revealed that resident #025 was found with an injury and moaning for pain on a specified date. The resident was transferred to hospital for further assessment and diagnosed with a particular medical condition.

Review of resident #025's written plan of care indicated that the resident had cognitive impairment and was to be turned and repositioned every two hours. According to the plan of care under the focus of activities of daily living (ADL) assistance, related to inability to follow instruction, the resident totally depends on two or more person physical assistance to turn side to side, and to move from lying position in bed due to their responsive and restless behavior.

Review of the nursing and personal care record (NPCR) for the month of October 2017, under bed mobility revealed that resident was turned and reposition by one person assistance during the night, day, and evening shifts on a specified date and during the night and day shifts on second specified date.

Interview with PCA #139 indicated being aware that resident #025 requires two person assistance at all times to turn and reposition them. However, they denied turning and repositioning the resident without assistance on the first specified date during the evening shift; this contradicted their documentation on the NPCR that indicated one person assistance under bed mobility.

In an interview, PCA #140 indicated that on the second specified date they were able to turn and reposition resident #025 without assistance as the resident was calm, which contradicted the resident's written plan of care.

In an interview, PCA #141 stated that they turn and reposition resident #025 every two hours with the help of charge nurse registered practical nurse (RPN) #142; this contradicted their documentation and the statement of RPN #142 that they did not help PCA #141 with bed mobility. The RPN also indicated that the resident was not aggressive or heavy, so one person could turn and reposition them.

DON #131 acknowledged that PCAs did not follow the resident's written plan of care when assisting resident #025. [s. 6. (7)]

5. The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

During stage one of the RQI the responsive behaviours inspection protocol (IP) triggered for resident #010.

A review of resident #010's MDS assessment revealed a change in their psychosocial well being response "at ease with others" from a response of no in November 2017, to a response of yes three months later in the most recent MDS assessment.

Observation of resident #010 on three specified dates in March 2018, revealed no negative behavioural expressions. Resident appeared at ease with others.

A review of resident #010's most recent written plan of care was observed in a resident home area (RHA) nursing station. The areas and dates of focus were observed to contain the following:
- ADL Assistance - Last update November 30, 2016; Next Review Date February 28, 2017,
- Mood State - Last update November 30, 2016; Next Review Date February 28, 2017,
- Pain - Last update November 30, 20116; Next Review Date February 28, 2017,
- Physio – Last update August 25, 2017; Next Review Date November 30, 2017,
- Activities Participation – Last update February 7, 2018; Next Review Date May 31, 2018,
- Nutritional Status – Last update March 1, 2018; Next Review Date May 30, 2018,
- Spiritual and Religious Care – Last update December 31, 2017; Next Review Date May 10, 2018.

There were no written plans of care for resident #010 in the binder for cognitive Loss, psychotropic medications, and behaviour problem.

An interview with PCA #145 revealed the interventions in the written plans of care were clear and easily accessible, but incomplete, therefore not accessible.

An interview with nurse manager (NM) #127 acknowledged the written plans of care for resident #010 were not current in the binder and were missing plans of care for cognitive loss, psychotropic medications, and behaviour problem; therefore, caregivers did not have current, convenient and immediate access to the written plan of care. [s. 6. (8)]

6. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

A complaint was received by the MOHLTC and indicated that stated resident #027 had been hospitalized three times for particular medical condition, that the resident's plan of care clearly indicated that the bed was to be kept at a certain angle, and was found to be flat.

The complainant was not able to be reached by phone and the request for a return call was unanswered.

A review of the progress notes revealed the resident had been on an identified diet texture for more than one year.

A review of the written plan of care on a specified date in July 2017, located in a care plan binder for PCA staff and others who did not have computer access, revealed the resident was to be kept upright for a specified time period to prevent a particular medical condition. The written plan of care dated March 4, 2018, which was located in the computer available to registered staff and not in the care plan binder available to PCA staff, stated to keep the resident in the upright position for different specified time period than the one mentioned above after each meal, to prevent the particular medical condition. A further review of the computer generated written plan of care revealed the plan of care was created on a specified date in April 2017, and last updated eleven months later, was not in the care plan binder.

Observations of resident #027 during the inspection, including several observations on revealed the resident to be sitting upright at 90 degrees at all times, which included after meals.The resident was never observed to be in bed at anytime.

An interview with PCA #119 revealed the plan of care of a specified date in July 2017, to which staff had access did not set out clear direction for the resident's current needs.

An interview with RN #121 revealed the written plan of care of the same specified date mentioned above located in the unit's care plan binder identified the resident was to be kept upright for a specified time period to prevent a particular medical condition. The current written plan of care of a specified date in March 2018, located in the computer stated the resident was to sit in an upright position after eating and drinking, for a different specified time period than the one indicated in the unit's care plan binder. In addition, the written plan of care updated in the computer in March 2018, was not located in the care plan binder for resident #027. RN #121 confirmed the written plan of care had not been updated in the care plan binder to reflect the resident's current needs, and therefore the written plan of care did not set out clear direction for staff regarding length of time the resident was to be positioned upright after meals.

An interview with the DON confirmed all written plans of care should be updated and available for staff in the care plan binder, and in this instance they were not for resident #027. [s. 6. (8)]

7. The licensee has failed to ensure that the provision of care as set out in the plan of

care was documented.

In the course of inspecting a complaint it was revealed that RN #132 failed to document care related to medication administration on a specified date in October 2017, for resident #035.

Review of the Medication Administration Record (MAR) for resident #035 on the above mentioned specified date revealed that several medications were not signed off in the MAR.

Interview with RN #132, revealed that the practice when administering medication was to sign for the medication at the time of administration.If there were issues of refusal or inability to administer, they should be documented with the correct code on the MAR as well as documented in the resident's progress notes and the 24 hour report.

Review of the MAR revealed many unsigned medications for the day shift on the above mentioned specified date for resident #035, and there were no progress notes, or notes in the 24 hour report to indicate issues related to medication administration that day.

Registered staff #134 revealed that they recall administering many medications to resident #035 that day, but could not recall details of what medications and if they signed for the medications.

Interview with NM #127 confirmed that medication administration are to be signed for as described above, and confirmed that there were several medications that were not documented as being administered for resident #035 on the specified date. [s. 6. (9) 1.]

8. During stage one of the RQI the hospitalization and change in condition IP triggered for resident #003.

Record review of resident #003's progress notes dated of a specified date in January 2018, indicated that the resident was observed by staff to be exhibiting signs and symptoms of infection, and also had a temperature. Three and four days later, the resident continued to experience a symptom of infection. There were no progress notes regarding the resident's status for the evening shift on the fifth day.

Record review of physician orders for resident #003 on a specified date in January 2018, indicated an order for a particular medication by mouth twice daily for a specified time

period, then to continue with the medication by mouth at a another specified frequency until the outbreak is over.

Record review of resident #003's written plan of care revealed a goal to fully treat the resident from a particular condition and its symptoms, and prevent transmission to other residents and the staff. The interventions included: administer medications as prescribed by MD, encourage extra fluid intake, monitor vital signs every shift until abnormal symptoms are resolved.

Interview with RPN #115 revealed that the home experienced an identified outbreak in January 2018 and resident #003 was line listed due to their symptoms. They stated that they worked evening shift on a specified date during the outbreak and should have documented the resident's signs and symptoms of infection in the progress notes including temperature on the vital signs record; they had to assist the PCA staff who were working short that evening. RPN #115 stated that the RN working with them should have completed the above mentioned documentation in the resident's progress notes and vital signs record but didn't, although they did monitor the resident during the shift and documented in the home's 24 hour report.

Interview with NM #116 revealed that the resident was exhibiting signs and symptoms of infection, tested positive for an infection in January 2018, and was placed on the home's line list. NM #116 stated that the home's expectation is that when resident's exhibit signs and symptoms of infection, registered staff should monitor and document in the progress notes on every shift. [s. 6. (9) 1.]

9. During stage one of the RQI the skin and wound IP triggered for resident #013.

A review of resident #013's paper record revealed the resident was admitted to the home in 2017, with two areas of altered skin integrity. The resident treatments and the areas of altered skin integrity were improving.

The policy nursing and personal care record, food and fluid intake stated, PCAs will document snack, fluid, and supplemental intake for each resident as they serve nourishment to ensure accuracy of documentation. The policy for snacks and supplemental service stated to document the amount of beverage/snack/supplement taken by residents in the NPCR, report to RN/RPN residents who do not take supplements and/or labelled snacks or beverages.

The current plan of care of a specified date in April 2018, revealed staff were to provide supplements as ordered.

A review of resident #013's NPCR records with the heading snacks for three specified months in 2018, revealed 24 dates that snacks consumed were not recorded.

A review of resident #013's NPCR records with the heading supplements with snacks for the three specified months mentioned above revealed 75 dates that the amount of supplements with snacks consumed were not recorded.

An interview with the registered dietitian (RD) #147 revealed the above policy had not been followed regarding the missing recorded amounts of snacks, and supplements with snacks, the resident received as noted above.

An interview with the DON revealed the policy for recording the amounts of snacks, and supplements and snacks, had not been followed as the record of recorded snacks and supplements and snacks was incomplete. [s. 6. (9) 1.]

10. A review of resident #013's clinical record revealed the resident was admitted to the home in 2017, with two areas of altered skin integrity. The resident had received treatments and the areas of altered skin integrity were reported to be improving.

A review of the home's policy skin care and wound prevention and management stated for stage one, two, three and four, to turn the resident using small position changes of 30 degrees to reduce pressure and to follow the turning schedule as per the plan of care.

The current plan of care revealed the resident was to be turned at a specified frequency.

A review of resident #013's NPCR records for two specified months in 2018, on 31 occasions and shifts indicated the resident turning and positioning schedule worksheet had not been documented as completed. For a specified month, the worksheet was not documented as completed for 12 specified days inclusive of all shifts. For 13 specified days in the same month there were 14 occasions and shifts that the turning and positioning schedule was not documented as completed.

An interview with RN #148 and RPN #156 revealed the turning and positioning worksheet for resident #013 was not documented as completed, as previously noted.

An interview with the DON revealed the expectation for staff to complete documentation related to resident care, and confirmed the documentation on the resident's turning and positioning schedule was not consistently documented as per the plan of care.

An interview with the DON confirmed resident #013's turning and positioning worksheet had not been completed according to the frequency specified in the resident's plan of care. [s. 6. (9) 1.]

11. The licensee has failed to ensure that when the resident is being reassessed and the plan of care revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Review of a CIS report submitted to the MOHLTC revealed that resident #024 had a fall in 2017, that resulted in an injury and they had surgery. According to the CIS report the resident was very forgetful and attempted to transfer without asking for assistance.

Review of the resident's fall history since their admission in the home revealed the following:
- On a specified date in 2017 the resident was assessed by the physiotherapist (PT) #157, documented that the resident was very unsteady on their legs and got tired easily with short distance,
- five days later in the morning, the PT followed up with resident and documented that they were able to ambulate with assistance of one staff to the dining room and in their room using rollater,
- later that day resident was found sitting on the floor in the common area. They had an injury to an identified body part,
- on a specified date the following month the resident was found on the floor next to their bed and near the window, resulting in an injury to two identified body parts, resident was transferred to hospital and returned on the same day with treatment to the two above mentioned identified body parts.The resident told the staff that they tried to close the blind and they fell,
- four days later in the morning the resident was found lying on the floor mat beside their bed. The resident told the staff that they wanted to go to the washroom, resulting in the existing injury, another injury to a body part, and discoloration on a third body part,
- later that day on the evening shift registered staff noted during hourly head injury routine (HIR) that resident #024 was disoriented,
- towards the end of the evening shift the resident was found lying on the floor outside their washroom with the washroom door closed. The resident was in supine position with

hip protectors on but no foot wear. The RN assessed the resident and found an injury. The resident was unable to move, verbally complaining of pain, and they were transferred to the hospital and diagnosed with a particular medical condition.

Review of the resident's written plan of care updated after each post-fall assessment for the 22 day time period mentioned above included the following fall prevention interventions:
- Involve resident #024 and/or family in developing a plan of care,
- consult with physician to review medications,
- keep adjustable bed in the lowest positions for safe transfers,
- promote proper use of handrails and handgrips,
- encourage resident #024 to wear well fitting, non-slip type shoes,
- encourage and remind resident #024 to ask for assistance with difficult tasks,
- call bell must be placed within easy reach.

In an interview, RPN #158 indicated that the resident was at high risk of falls. The RPN also indicated that the resident had moderate cognitive impairment; the resident used to climb out of the bed and get out of the chair. They indicated that the falls prevention interventions in place included: keep the bed in lowest position as possible, floor mat at each side of the bed, call bell close by, staff to check on the resident to ensure they are resting, and get them involved in activities to keep them distracted. The RPN stated that physiotherapists were part of the falls prevention team and relied on their recommendation to reduce the risk of fall.

In an interview, PT #157 indicated that they had assessed the resident after each fall and they had not considered different approaches during the assessment after each fall. They stated that they should have tried a bed alarm, a toileting schedule, and close monitoring to reduce the risk of fall.

In an interview ANM #126 indicated that the falls prevention interventions implemented for resident #024 were not effective for the following reasons:
- telling a resident who is moderately impaired to use the call bell was not effective, because the resident will not remember,
- telling the resident to ask for assistance with toileting was not effective because the resident had short term memory problem and an intake long term memory, they will remember to walk and to use the walker, and not call for assistance,
- placing the bed in lowest position was not safe as the resident will lose balance and fall

when they try to get up,
- use of crash mats on the floor was a hazard for resident #024 as they may trip trying to get up and walk.

NM #126 indicated that the interventions identified above for resident #024 were not effective and they should have considered different approaches that included the bed alarm that will alert staff when the resident tries to get up, and toileting plan. [s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident, that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, that provision of the care set out in the plan of care is documented, and that when the resident is being reassessed and the plan of care revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The hospitalization and change in condition inspection protocol (IP) triggered from stage one of the RQI related to symptoms of infection for resident #004.

Review of resident #004's progress notes for a specified date in January 2018, indicated that a PCA staff reported that the resident was in bed and felt hot with a temperature. Progress notes indicated that for the following three consecutive days the resident was isolated in their room and had developed a cough; their temperature the next day had increased and the physician ordered analgesic, antibiotic therapy and anti-viral medication; the resident remained on isolation precautions. On a specified date in January 2018 progress notes did not include documentation of the resident's symptoms of infection on the evening shift. Later that month isolation precautions was discontinued for the resident, temperature was decreased and symptoms were still noted.

Record review of the resident's written plan of care revealed a goal to fully treat them from a particular condition and it symptoms and prevent transmission to other residents and staff. Interventions included administer anti-viral as prescribed by physician, encourage extra fluid intake, and monitor vital signs every shift until abnormal symptoms are resolved.

Interview with RPN #114 revealed that they worked on a specified date in January 2018, and couldn't remember if they monitored the resident's symptoms of infection and

temperature, and did not document the same in the resident's progress notes. RPN #114 stated that they may not have received a report about the resident's symptoms of infection from the previous shift.

Interview with acting nurse manager (ANM) #106 revealed that the home experienced an identified outbreak in January 2018, and it was declared over 35 days later.

Interview with RNs #101 and #102 revealed that when residents are experiencing signs and symptoms of infection they should be monitored every shift, with temperature taken and documentation completed in the progress notes; they stated that there were no progress notes indicating that it was done for resident #004 on the above mentioned specified date in January 2018.

Interview with infection prevention and control (IPAC) lead #116 indicated that the home's expectation was that residents' experiencing symptoms of infection should be monitored every shift, including temperature taken and documentation completed in their progress notes. They stated resident #004 should have been monitored for symptoms of infection by RPN #114 as mentioned above. [s. 229. (5) (a)]

2. The licensee has failed to ensure that on every shift, the symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required.

The hospitalization and change in condition IP triggered from stage one of the RQI for resident #005 related to infection.

Review of the resident's most recent RAI-MDS assessment identified resident #005 as having a particular infection and in December 2017, a diagnostic test confirmed a particular medication condition.

Review of progress notes revealed that on a specified date, the resident exhibited a symptom of infection and the body temperature. Further review of the progress notes revealed the sign and symptoms were not documented during two shifts on a specified date in January 2018, and during two shifts the following day.

In an interview RPN #129 stated that they had monitored resident #024 during one shift on the second of the above mentioned specified date as evidenced by a nursing report of the same date; however, they did not document the signs and symptoms of the resident’s

infection in the progress notes.

In an interview with IPAC lead #116 they stated that the home's expectation is that staff should document residents' signs and symptoms of infection during each shift from the onset, until the treatment ordered is completed, the resident is assessed and outcome noted in the doctor's book. IPAC lead #116 acknowledged that staff did not continuously documented the signs and symptoms of the infection until when the resident's antibiotic therapy ended. [s. 229. (5) (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 on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and that the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

During stage one of the RQI the personal support services IP triggered related to no oral hygiene assistance for resident #007.

Record review of resident #007's most recent written plan of care indicated that the resident required one person assistance with mouth care.

On a specified date in March 2018, during interview with resident #007 they reported that although personal hygiene was provided that morning, no one had offered or assisted them to brush their teeth. The resident stated that they had all their own natural teeth, was unable to do their own oral hygiene, and since admission to the home a few months ago, oral hygiene had never been offered or done twice per day as required.They further stated that 80% of the time assistance with oral hygiene was done once per day before bed, but not offered in the mornings.

On the specified date in March 2018, mentioned above, during interview PCA #117 reported that they were assigned to resident on the day shift and provided personal hygiene assistance in the morning. PCA #117 stated that the resident was alert and able to direct her own care, required assistance with personal and oral hygiene, but had refused oral hygiene assistance that morning.

Observation of resident #007's electric toothbrush in the resident's washroom was completely dry when wiped with a napkin.

Re-interview with resident #007 revealed that the above mentioned PCA did not bring up the subject of brushing their teeth at all that morning, nor offer any assistance with it during morning care. [s. 34. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

During stage one of the RQI the skin and wound IP triggered related to altered skin integrity for resident #013.

A review of resident #013's clinical record revealed the resident was admitted to the home with two areas of altered skin integrity. The resident was receiving treatments and the areas of altered skin integrity were improving.

An interview with the wound care lead revealed residents who had altered skin integrity were to be assessed weekly, using the weekly ulcer/wound assessment record.

A review of the above mentioned record for a three month period revealed skin and wound assessments were not completed for a two week period in 2018.

An interview with RN #148 revealed skin and wound assessments were not completed for a two week period as mentioned above.

An interview with the DOC confirmed that the policy of the home was to complete and document weekly skin and wound assessments for residents with wounds; the assessments were not completed for a two week period for resident #013. [s. 50. (2) (b) (iv)]

Issued on this 7th day of June, 2018

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) :	THERESA BERDOE-YOUNG (596), CECILIA FULTON (618), JUDITH HART (513), JULIENNE NGONLOGA (502), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2018_525596_0003
Log No. / No de registre :	004872-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 4, 2018
Licensee / Titulaire de permis :	City of Toronto 55 John Street, Metro Hall, 11th Floor, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	Kipling Acres 2233 Kipling Avenue, ETOBICOKE, ON, M9W-4L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Robert Petrushewsky

To City of Toronto, 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. 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.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.36.
Specifically, the licensee must ensure the following:

- staff use resident #026's wheelchair with the footrests in the home at all times while the resident is being pushed in it.
-staff use safe transferring and positioning devices or techniques when assisting all residents.
-all resident care staff to be educated regarding the above mentioned expectations and attendance records are to be maintained.

Grounds / Motifs :

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

Review of critical incident system (CIS) report submitted to the ministry of health and long term care (MOHLTC) revealed that resident #025 was found with an injury and moaning for pain on a specified date. The resident was transferred to hospital for further assessment and diagnosed with a particular medical condition.

Review of the home's investigation revealed that on the day before the resident was discovered with an injury, personal care assistants (PCA) #124 and #138 had transferred resident #025 using one identified lift, instead of another identified lift that should have been used for the resident; they were both disciplined.

Review of resident #025's written plan of care under the focus of activities of

daily living (ADL) assistance, related to inability to follow instruction revealed that the resident was totally dependent on two or more person physical assistance for transfers using an identified lift. According to the plan of care the resident had cognitive impairment.

In separate interviews, PCAs #139, #138 and #124 acknowledged being aware that resident #025 required use of the identified lift indicated in the resident's written plan of care, for all transfers. They still used the wrong lift to transfer them onto the toilet, as they could stand and walk when they were in a good mood.

PCA #138 confirmed that they assisted PCA #124 on the above mentioned specified date before dinner to change resident #025's incontinence product in the spa room, using a different lift from the one specified in the resident's plan of care. PCA #138 stated that the resident was able to weight bear and hold but not able to follow directions.

PCA #124 confirmed that they used the wrong lift to change resident #025's continence product in the spa room before dinner. The PCA indicated that it was not the first time they used the wrong lift as the resident will stand for them.

The director of nursing (DON) #131 acknowledged that both PCAs did not use safe transfer techniques when assisting resident #025 with toileting. They indicated that the home's expectation was for staff to follow the resident's written plan of care. [s. 36.] (502)

2. Review of a CIS report submitted to the MOHLTC revealed resident #026 reported that staff had injured them while they ambulated on the unit on a specified date. The resident had complained of pain to an identified body part, and swelling and a particular injury were noted on another body part.

Review of resident #026's progress notes revealed that on a specified date at 2230 hours, the resident had injured them while being pushed in their wheelchair by a staff member. The resident complained of pain to an identified body part, and swelling and a particular injury was noted on another body part. The next day the resident was not able to weight bear, was assessed by the home's physician and sent to the hospital for further assessment.

Review of a consultation report from William Osler Health System six days later

indicated that resident's identified body part was obviously deformed with a particular diagnosis, a second identified diagnosis and a particular injury. The resident's identified body part was tender and they were neurologically intact. A diagnostic test confirmed the above mentioned diagnoses.

Review of the resident's minimum data set (MDS) annual assessment dated two months earlier indicated that the resident had short and long-term memory problem, and they were moderately Impaired in their ability to make decisions.

During interview PCA #144 indicated that they were wheeling the resident before breakfast from their bedroom to the dining room. The PCA stated that they stopped on the way to answer another resident's call bell. When they returned they continued to push the resident not knowing that the resident had placed their foot behind the footrest. They confirmed that they did not tilt the wheelchair when pushing the resident.

In an interview Nurse Manager (NM) #118 stated that they had discussed it with the PCA at the time of incident. NM #118 indicated the foot rest was folded up to allow the resident to ambulate independently for short distances. However, at the time of the incident PCA #144 forget to place them properly before assisting the resident to ambulate using the wheelchair.

In an interview, physiotherapist (PT) #143 stated that they assessed resident #026 three months earlier and educated the nursing staff about resident #026's specific wheelchair. According to PT #143 they told the nursing staff to ensure that the resident's feet were supported on the footrest, the wheelchair tilted to a certain degree so that the feet were not caught in between the chair. PT #143 stated resident #026's specific wheelchair was not used properly because the resident was able to place their foot on the floor while being pushed; this resulted in a change of the resident's condition and their transfer status changed from two person to two person using an identified lift, as they were unable to walk. [s. 36.] (596)

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was level three as it related to two out of two residents reviewed. The home had a level 2 history as they had previous unrelated non-compliances.
(502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 4th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa Berdoe-Young

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