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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 18, 2016	2016_325568_0011	008065-16	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

DOROTHY GINTHER (568), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 17, 18, 22, 23, 2016

Inspector Sherri Cook (633) was also involved with this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, Administrator, Director of Nursing Care, Environmental Services Manager, Scheduling Coordinator, one Registered Dietitian, one Registered Nurse, four Registered Practical Nurses, one Registered Practical Nursing student, one Neighbourhood Coordinator, eight Personal Care Aides, one Environmental Services staff, one Maintenance staff, and a Police Constable.

The Inspector(s) also observed the provision of care for the identified residents and other residents on an identified neighbourhood and resident-staff interactions; reviewed clinical records for the identified residents, investigation notes, relevant policies and procedures, staffing schedules, and the Bed System Inspection Sheet.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 VPC(s)**
- **4 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Documentation review revealed that resident #001 had an area of altered skin integrity, and developed another area of altered skin integrity. Resident #001 was assessed by the Registered Dietitian (RD) #109 related to their weight being below the goal weight range. The RD #109 ordered a supplement to be given at breakfast and lunch.

The Medication Administration Record (MAR) indicated that a supplement was to be given at breakfast and lunch. There was no documentation to indicate that the supplement was given to resident #001 at breakfast or lunch for a three week period before the order was discontinued.

During an interview with Registered Practical Nurse (RPN) #104 they acknowledged that an order had been written by the RD #109 for a supplement to be given to resident #001 at breakfast and lunch. The expectation would be that when staff provided the resident with the supplement they would sign off in the MAR that it had been given. RPN #104 confirmed that the supplement had not been signed for on the MAR at either breakfast or lunch for a three week period, which would indicate that it had not been given.

The licensee failed to ensure that the nutritional supplement outlined in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Documentation review of the Schelegel Villages Entrapment Inspection Sheet identified the specifications for resident #001's bed which included a specific bed frame, blue mattress, and bed rails. It indicated that the bed in resident #001's room had passed testing for entrapment in zones one to four and that zones six and seven were "ok".

During observations it was noted that the mattress on resident #001's bed was purple and there were two quarter bed rails up at the head of the bed. The Director of Nursing Care (DONC) #101 reported that there was no recent mattress change. During an interview with the Environmental Services Manager (ESM) #123 they confirmed that a requisition for a mattress change had not been submitted for resident #001's bed. The ESM #123 reported that often the nursing staff, including the DONC and ADONC, change the mattresses on their own and the Environmental Services department would not be notified.

Staff interview with four Personal Care Aides (PCA) #103, #108, #110, #114 and a RPN #120 revealed that resident #001 did not use their bed rails to assist with repositioning or maintaining their position while staff provided care.

The home's policy entitled "Bed Entrapment & Bedrail Assessment (tab 06-02) dated

November 6, 2015 identified that residents would be assessed for their use of bed rails using the Bed Rail Assessment / Decision Tree (appendix C). Residents would be assessed on move-in and at any time when a change in bed rail use was required. In terms of bed entrapment, the policy indicated that the Village would complete an entrapment audit on the 7 zones annually, within 24 hours of a Resident moving in, and within 24 hours of when a bed frame, surface, or any other component(s) of the bed had been altered or changed. Zones one to four would be tested utilizing a bed entrapment device.

During an interview with the DONC #101 they reported that with the assistance of two registered staff they had tested all of the beds in the home with respect to entrapment in July 2015. The home had purchased a bed entrapment testing tool which was used to test zones one to four. The DONC #101 acknowledged that when changes were made to the bed systems i.e. mattress, bed rails or frame, the beds were not being retested and the home did not currently have a system to track these changes. The DONC #101 confirmed that resident #001's mattress had been changed from a blue to a purple mattress following the testing on July 11, 2015 and the bed had not been retested. The DONC #101 also confirmed that resident #001 had not been assessed with respect to the use of bed rails. The home recently adopted a Bed Rail Assessment / Decision Tree but they had not yet implemented it. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Documentation review revealed that resident #002 exhibited responsive behaviors. Interventions identified in the plan of care included redirection from other resident rooms, safety checks when the the resident was not in common areas, and supervision when interacting with peers to ensure safety.

During observations over a 90 minute period resident #002 was not found in their room. A Registered Practical Nurse #104 was asked where the resident could be found. The staff member began a search and found resident #002 in another resident's room. The staff member identified the resident for the inspector and then left the room leaving the resident. Resident #002 was observed to go into four different resident rooms during a fifteen minute period, one of which was their own. Resident #002 exhibited responsive behaviors toward another resident while in one of the rooms. During the more than 90 minutes of observation the inspector did not observe any staff check on resident #002 when they were not in their room and when they were observed exhibiting responsive behaviors toward another resident.

During a second observation period resident #002 was not found in their room or in the common areas of the neighbourhood. Resident #002 was found by an inspector in resident #003's room. Neighbourhood Coordinator (NC) #102 brought resident #002 back out to the hall, opposite to where their room was located, and left them.

During staff interviews with five Personal Care Aides #103, #107, #108, #110, #114 and one Registered Practical Nurse #120 they shared that Resident #002 exhibited responsive behaviors and there had been altercations with other residents.

When staff were asked what strategies and interventions had been put in place to monitor resident #002 and limit conflict with other residents, PCA's #103 and #108 reported that they do their best to monitor resident #002 but it can be challenging while providing care for other residents. When possible they redirect the resident to an appropriate location.

RPN #124 identified specific behaviors that would be documented as incidents.

Wandering, voiding in inappropriate locations and any kind of altercation between residents and staff, verbal or physical, that was confirmed by staff as responsive behaviors would be documented as an incident. An incident report would be completed, note left in the communication binder, progress note documented in the electronic record, and referral made to the in house behavioral support team which was called the Personal Expression Team. The physician would also be notified via the physician log book.

RPN #120 shared that staff had reported conflict / altercations between resident #002 and other residents during shift report. Review of the communication binder / shift report records for the identified neighbourhood revealed one notation of resident #002's responsive behaviors during the last month. The physician had requested an assessment of resident #002's responsive behaviors because of reported conflict with other residents. RPN #118 / lead for the Personal Expression Team confirmed that resident #002 had not been referred to the PE Team.

During an interview with the Administrator #100 and Director of Nursing Care #101 they indicated that it was the home's expectation that safety checks be completed on a regular basis when identified in the plan of care. When asked what time frame safety checks were to be completed the Administrator and DOC indicated that this had not been established in the home and currently the home did not have a system for documenting these checks. The Administrator #100 acknowledged that resident #002 exhibited responsive behaviors which posed a potential risk to other residents, and interventions had not been implemented to minimize the risk of altercations and potentially harmful interactions between resident #002 and other residents. [s. 54. (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Record review revealed that resident #001 was to be turned/repositioned in bed every two hours and as needed. The resident had areas of altered skin integrity.

During interviews with three Personal Care Aides (PCA) #114, #103 and #108 they reported that resident #001 was unable to reposition themselves in bed. PCA #114 indicated that on the identified date they had repositioned resident #001 twice on the night shift. PCA #103 shared that because resident #001 slept in they did not provide care until late morning on day shift. PCA's #103 and #114 acknowledged that resident #001 should be repositioned every two hours but indicated that it was impossible given the workload.

The Personal Assistive Service Device (PASD) Repositioning Record for resident #001 over a sixteen day period revealed that there were 5/16 days where the resident was not repositioned for eight hours and 3/16 days where the resident was not repositioned for a period of eighteen hours.

The Administrator #100 and Director of Nursing Care #101 indicated that it was the home's expectation that residents that were dependent in terms of mobility would be repositioned every two hours whether they were in a wheelchair or bed. This would be outlined in the resident's plan of care. The Administrator acknowledged that resident #001 had altered skin integrity and required staff assistance to reposition. They confirmed that the resident had not been repositioned every two hours. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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.

Documentation review revealed that #002 exhibited responsive behaviors.

During observations over a 90 minute period resident #002 was not found in their room. A Registered Practical Nurse #104 was asked where the resident could be found. The staff member began a search and found resident #002 in another resident's room. The staff member identified the resident for the inspector and then left the room leaving the resident. Resident #002 was observed to go into four different resident rooms during a fifteen minute period, one of which was their own. Resident #002 exhibited responsive behaviors toward another resident while in one of the rooms. During the more than 90 minutes of observation the inspector did not observe any staff check on resident #002 when they were not in their room and when they were observed exhibiting responsive behaviors toward another resident.

During a second observation period resident #002 was not found in their room or in the common areas of the neighbourhood. Resident #002 was found by an inspector in resident #003's room. NC #102 brought resident #002 back out to the hall, opposite to where their room was located, and left them.

During staff interviews with five Personal Care Aides #103, #107, #108, #110, #114 and one Registered Practical Nurse #120 they shared that resident #002 exhibited responsive behaviors and there had been altercations with other residents.

When staff were asked what strategies and interventions had been put in place to monitor resident #002 and limit conflict with other residents, PCA's #103 and #108 reported that they did their best to monitor resident #002 but it could be challenging while providing care for other residents. When possible they redirected the resident to an appropriate location.

RPN #120 shared that staff had reported conflict / altercations between resident #002 and other residents during shift report. The RPN was not aware of the specifics of the conflict but understood that other residents were upset by the altercations.

The Administrator #100 indicated that it was the home's expectation that safety checks be completed on a regular basis when identified in the plan of care. When asked what time frame safety checks were to be completed the Administrator #100 and DONC #101 indicated that this had not been established in the home and currently the home did not have a system for documenting these checks. The Administrator #100 acknowledged that resident #002 exhibited responsive behaviors which posed a potential risk to other residents2 and confirmed that the home had not protected all residents from abuse. [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 from anyone and not neglected by the licensee or staff., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behavior plan of care was based on an interdisciplinary assessment of the resident that included any mood and behavior patterns, including wandering, any identified responsive behaviors and any potential behavioral triggers and variations in resident functioning at different times of the day.

During interviews with three Personal Care Aides (PCA) #114, #107, #108 and Registered Practical Nurse (RPN) #120 they shared that resident #002 exhibited responsive behaviors which were more prevalent at certain times of the day.

Record review revealed that resident #002's plan of care did not identify their pattern of behaviors and the variation at different times of the day. The Administrator #100 acknowledged and confirmed that resident #002's behavior patterns and variations in functioning at different times of the day were not included in the plan of care [s. 26. (3) 5.]

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 responsive behavior plan of care was based on an interdisciplinary assessment of the resident that includes any mood and behavior patterns, including wandering, any identified responsive behaviors and any potential behavioral triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

Review of resident #002's plan of care revealed that they liked to get up in the morning between 0700 - 0730 hours. Staff were encouraged to invite the resident to meals and if they declined to attend they were to offer them a tray. When the resident refused meals they were to offer fluids and snacks throughout the day.

During interviews with two Personal Care Aides (PCA) #103 and #110 they indicated that resident #002 did not always come down for breakfast. When the resident did not attend breakfast PCA #110 reported that a tray was not usually offered. PCA #110 reported that intake for meals and snacks was documented on the Nutrition and Hydration Flow sheets. If the resident refused this was identified on the flow sheet by circling the "R". If the resident did not attend the meal they usually stroked off the area and indicated "0" for intake.

Review of the Nutrition and Hydration Flow Sheets for resident #002 over a six week period indicated that the resident was not offered breakfast on 37/51 days, refused on 2/51 days and ate all of their breakfast on 12/51 days.

During an interview with the Administrator #100 and Director of Nursing Care (DONC) #101 they acknowledged that residents should be offered a minimum of three meals a day unless otherwise documented in their plan of care. If the resident was not awake in the morning for breakfast then a tray should be provided and the required assistance with eating as per the plan of care. The DONC #101 confirmed that resident #002 should have either been brought to the dining room for breakfast or offered a tray when they got up.

The licensee failed to ensure that resident #002 was offered three meals a day. [s. 71. (3) (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 is offered a minimum of three meals daily., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following evidence is further grounds to support compliance order #001 issued on March 17, 2016 inspection #2016_448155_0002 with a compliance date of May 16, 2016.

1. The home's policy titled "Nutrition and Hydration" (Tab 07-24) dated April 2014, indicated that each evening the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse (RPN/RN) would review and initial the total daily fluid intake. Any resident who had a fluid intake, less than their estimated fluid requirements, would be reported to the oncoming RPN/RN so that interventions could be initiated. The RPN/RN would assess for signs and symptoms of dehydration (Dehydration Risk Assessment Tool). If a resident exhibited signs and

symptoms of dehydration, they would ensure the request for Nutrition consultation had been initiated for the Registered dietitian to assess. The request for Nutrition Consultation (Tab 07-41) is completed when a resident has a fluid intake of less than 1000 milliliters (mls) or per individual fluid requirement as per the Plan of Care for three consecutive days and there was at least one sign or symptom of dehydration present.

Review of the Dehydration Report for a 13 day period in one month identified that resident #001's recommended intake was 1750 mls. Resident #001's recommended intake was below the recommended intake and below 1000 mls on 9/13 days. On 3/13 days the documented intake was incomplete. There was only one day out of thirteen where resident #001 exceeded the 1000 mls intake. The Dehydration Report for an eight day period on a second month identified that resident #001's intake was below their recommended intake and 1000 mls on 6/8 days and was incomplete on 1/8 days. There was just one day out of eight where the resident's intake exceeded 1000 mls. Record review revealed that there were no Dehydration Risk Assessments completed for resident #001.

During an interview with Registered Practical Nurse #121 they reported that registered staff review the total intake for each resident on a daily basis. If the resident's fluid intake was below their requirement for three consecutive days then they would refer the resident to the Registered Dietitian. When the staff member was asked if they would complete a Dehydration Risk Assessment they indicated that they were not aware that this assessment was required. When shown the Dehydration Report for for the two periods outlined above, RPN #121 acknowledged and confirmed that resident #001's fluid intake was below their recommended consumption and also below the 1000 mls as outlined in the home's policy.

Interview with Registered Dietitian (RD) #109 revealed that when a resident's fluid consumption is less than 1000 mls for three consecutive days then registered staff should complete a Dehydration Risk Assessment and based on the assessment of low intake they would refer to the Registered Dietitian (RD). The RD #109 confirmed that a Dehydration Risk Assessment had not been completed for resident #001 during the periods identified and they were not referred to the RD related to this risk.

2. The home's policy entitled "Wound / Skin Care" (Tab 04-78) dated January 9, 2015 indicated that on an ongoing basis, the PCA would complete the Skin Assessment, typically on each bath day, and record on the Resident's Flow Sheets if no concerns needed to be addressed. If there was a concern, it would be documented using the

Twice Weekly Skin Assessment Form and a Skin Assessment Concerns Form would be completed and given to the Registered Team Member.

Record review revealed that resident #001 had an area of altered skin integrity and developed another area of altered skin integrity. Review of resident #001's clinical record did not reveal a Twice Weekly Skin Assessment Form or a Skin Assessment Concern Form related to the newly acquired area of altered skin integrity. There was no documentation in the Personal Care Observation and Monitoring Form for a one week period to indicate that resident #001 was bathed and that a skin assessment was completed twice weekly as per the home's policy.

The Director of Nursing Care #101 acknowledged that twice weekly skin assessments were not completed for resident #001 on their bath days and confirmed that the home had not complied with their Wound / Skin Care policy.

3. The home's policy entitled "Personal Expression Program using the Layered Natured Framework and the P.I.E.C.E.S Approach (Tab 04-84) dated February 17, 2015 under Procedure indicated that if a resident was identified as Potential Risk the Neighbourhood Team leader (NC)/Designate would:
1. Contact their NC and Physician to discuss the reason for referral. NC would initiate conversation with the Resident's POA regarding status and need for referral to the Villages' Personal Expression Resource Team (PE-Resource Team).
2. Send a referral (if agreed upon by the NC/Physician) to the PE-resource Team and discuss with the Director of Nursing Care (DNC) to determine if 1:1 should be initiated.
3. Initiate assessments as discussed with the physician and the PE-Resource Team
4. Document in the Resident's electronic Progress Notes the details above and the current plan of action

Documentation review revealed that resident #002 exhibited responsive behaviors.

During observations over a 90 minute period resident #002 was not found in their room. A Registered Practical Nurse #104 was asked where the resident could be found. The staff member began a search and found resident #002 in another resident's room. The staff member identified the resident for the inspector and then left the room leaving the resident. Resident #002 was observed to go into four different resident rooms during a fifteen minute period, one of which was their own. Resident #002 exhibited responsive behaviors toward another resident while in one of the rooms. During the more than 90 minutes of observation the inspector did not observe any staff check on resident #002

when they were not in their room and when they were observed exhibiting responsive behaviors toward another resident.

During staff interviews with five Personal Care Aides #103, #107, #108, #110, #114 and one Registered Practical Nurse #120 they shared that resident #002 had exhibited responsive behaviors and there had been altercations with other residents.

Interview with the lead for the PE-Resource Team #118 revealed that all staff are encouraged to refer residents to the program through referral either paper based or verbal. When asked how resident's were identified as either a potential or actual risk as per the home's policy the staff member was unsure. The PE-Resource Team Lead #118 confirmed that resident #002 was not currently being followed by the PE-Resource Team.

During an interview with the Administrator #100 they were asked whether resident #002 would be deemed either a potential or actual risk given the observations and descriptions provided by staff. The Administrator #100 acknowledged that at a minimum resident #002 would be a potential risk and confirmed that resident #002 should have been followed by the home's PE-Resource Team given the resident's level of risk as identified by the Personal Expression program policy.

The licensee failed to ensure that the home's policies related to Nutrition-Hydration, Wound/Skin Care, and the Personal Expression program were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The following evidence is further grounds to support the compliance order #003 issued on March 17, 2016 inspection #2016_448155_0002 with a compliance date of April 29, 2016.

a) Record review revealed that resident #001 required staff assistance to turn/reposition in bed every two hours and as needed. The resident had areas of altered skin integrity. The PASD Repositioning record for resident #001 on an identified date indicated that the resident was repositioned at 0000, 0200, and 0400 hours on night shift.

The PASD Repositioning Record for resident #001 for a sixteen day period revealed no documentation that the resident was repositioned for a period of eight hours on 5/16 days and for a period of eighteen hours on 3/16 days.

During interviews with three personal Care Aides (PCA) #114, #103, and #108 they reported that resident #001 was dependent for care and unable to reposition themselves

in bed. PCA #114 shared that while working the night shift on an identified date resident #001 had been changed and repositioned on two occasions during their shift from 2200 – 0600 hours. The staff member shared that with her team member they had changed and repositioned the resident at 2300 hours and again at approximately 0530 hours. When asked why documentation indicated that the resident had been repositioned every two hours and was last seen at 0400 hours, the staff member indicated that the documentation was not accurate. PCA #114 reported that on the night in question they were extremely busy and did not have time to complete the repositioning as directed by the plan of care. The staff member shared that this happened quite often on night shift because you only had two staff regularly scheduled and depending on resident care needs it was difficult to get everything done.

During an interview with PCA #103 and #113 they reported that PCA staff do not have a particular resident assignment on the neighbourhood. When asked how they know what residents have been seen and have had their care, they indicated that they talk to one another regarding what has been done and what still needs to be done.

Staff interview with RPN #104 revealed that just prior to the end of a shift they would complete a quick check of all the residents. When asked if this was a practice that all registered staff in the home conducted the staff member could not confirm. During an interview with RN #115 they shared that the process when shifts are changing would be that the Personal Care Aides coming on shift should do a quick check of all of the residents on the unit.

b) During observations over a 90 minute period resident #002 was not found in their room. A Registered Practical Nurse #104 was asked where the resident could be found. The staff member began a search and found resident #002 in another resident's room. The staff member identified the resident for the inspector and then left the room leaving the resident. Resident #002 was observed to go into four different resident rooms during a fifteen minute period, one of which was their own. Resident #002 exhibited responsive behaviors toward another resident while in one of the rooms. During the more than 90 minutes of observation the inspector did not observe any staff check on resident #002 when they were not in their room and when they were observed exhibiting responsive behaviors toward another resident.

Documentation review revealed that resident #002 exhibited responsive behaviors. Interventions identified in the plan of care included redirection from other resident rooms, safety checks wen the the resident was not in common areas, and supervision when

interacting with peers to ensure safety.

The Administrator #100 and Director of Nursing Care #101 acknowledged that safety checks were not being conducted for resident #002 at a sufficient frequency, the resident was not being redirected from other resident rooms, and the resident was not being supervised at all times when interacting with other residents.

c) Review of resident #002's plan of care revealed that they liked to get up in the morning between 0700 – 0730 hours. It was indicated that the resident should be invited to meals. Staff were encouraged to save the resident a tray if they were not accepting of meals, and to offer fluids and snacks throughout the day.

During interviews with two Personal Care Aides (PCA) #103 and #110 they indicated that resident #002 liked to sleep in and did not usually attend breakfast. The staff indicated that it was not their practice to provide trays for residents that did not come down for breakfast. Mornings were very busy assisting in the dining room and completing am care.

Review of the Nutrition and Hydration Flow Sheets for resident #002 over a six week period indicated that the resident was not offered breakfast on 37/51 days, refused on 2/51 days and ate all of their breakfast on 12/51 days.

During an interview with the Administrator #100 and Director of Nursing Care #101 they acknowledged that residents should be offered a minimum of three meals a day. The Director of Nursing Care #101 confirmed that staff should have either brought resident #002 to the dining room for breakfast or offered them a tray when they got up.

e) Interview with the Scheduling Coordinator #119 revealed that the regular staffing for Personal Care Aides on Nichol Neighbourhood was as follows:
•Days – three staff 0600 – 1400 hours; one staff 0700 – 1500 hours
•Evenings – three staff 1400 – 2200 hours; one staff 1500 – 2300 hours; and one staff in the lounge 1600 – 2000 hours
•Nights – two staff 2200 – 0600 hours

During a five day period an identified neighbourhood was short one staff on 4/5 evening shifts; and one staff on 1/5 night shifts. The Staffing Coordinator indicated that they do their best to fill vacant shifts but this was not always possible.

The Administrator #100 acknowledged that residents' assessed care and safety needs were not being met by the current staffing mix. [s. 31. (3) (a)]

Issued on this 11th day of May, 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_325568_0011
Log No. / Registre no:	008065-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 18, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

To Schlegel Villages Inc, 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 :

The licensee shall ensure that where a resident is identified in the plan of care as requiring a supplement, the supplement is provided to the resident as set out in the plan of care, and the residents intake of the supplement is documented.

Grounds / Motifs :

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

Documentation review revealed that resident #001 had an area of altered skin integrity, and developed another area of altered skin integrity. Resident #001 was assessed by the Registered Dietitian (RD) #109 related to their weight being below the goal weight range. The RD #109 ordered a supplement to be given at breakfast and lunch.

The Medication Administration Record (MAR) indicated that a supplement was to be given at breakfast and lunch. There was no documentation to indicate that the supplement was given to resident #001 at breakfast or lunch for a three week period before the order was discontinued.

During an interview with Registered Practical Nurse (RPN) #104 they acknowledged that an order had been written by the RD #109 for a supplement to be given to resident #001 at breakfast and lunch. The expectation would be that when staff provided the resident with the supplement they would sign off in the MAR that it had been given. RPN #104 confirmed that the supplement had not been signed for on the MAR at either breakfast or lunch for a three week period, which would indicate that it had not been given.

The licensee failed to ensure that the nutritional supplement outlined in the plan of care was provided to resident #001 as specified in the plan.

The severity of this noncompliance was identified as a level three - actual harm/risk. The scope was isolated. the compliance history was a level four - despite Ministry of health action (VPC, Order) noncompliance continues with original area of noncompliance. this area of noncompliance was issued may 11, 2015, October 15, 2014, October 16, 2013 and July 15, 2013 as a VPC. It was issued as a compliance order on April 14, 2014.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used;
(i) the resident is assessed and
(ii) his or her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident, including when there has been a change to the resident's bed system. The home shall ensure that there is an organized method to track changes to resident's bed systems.

Grounds / Motifs :

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

Documentation review of the Schelegel Villages Entrapment Inspection Sheet identified the specifications for resident #001's bed which included a specific bed frame, blue mattress, and bed rails. It indicated that the bed in resident #001's room had passed testing for entrapment in zones one to four and that zones six and seven were "ok".

During observations it was noted that the mattress on resident #001's bed was purple and there were two quarter bed rails up at the head of the bed. The

Director of Nursing Care (DONC) #101 reported that there was no recent mattress change. During an interview with the Environmental Services Manager (ESM) #123 they confirmed that a requisition for a mattress change had not been submitted for resident #001's bed. The ESM #123 reported that often the nursing staff, including the DONC and ADONC, change the mattresses on their own and the Environmental Services department would not be notified.

Staff interview with four Personal Care Aides (PCA) #103, #108, #110, #114 and a RPN #120 revealed that resident #001 did not use their bed rails to assist with repositioning or maintaining their position while staff provided care.

The home's policy entitled "Bed Entrapment & Bedrail Assessment (tab 06-02) dated November 6, 2015 identified that residents would be assessed for their use of bed rails using the Bed Rail Assessment / Decision Tree (appendix C). Residents would be assessed on move-in and at any time when a change in bed rail use was required. In terms of bed entrapment, the policy indicated that the Village would complete an entrapment audit on the 7 zones annually, within 24 hours of a Resident moving in, and within 24 hours of when a bed frame, surface, or any other component(s) of the bed had been altered or changed. Zones one to four would be tested utilizing a bed entrapment device.

During an interview with the DONC #101 they reported that with the assistance of two registered staff they had tested all of the beds in the home with respect to entrapment in July 2015. The home had purchased a bed entrapment testing tool which was used to test zones one to four. The DONC #101 acknowledged that when changes were made to the bed systems i.e. mattress, bed rails or frame, the beds were not being retested and the home did not currently have a system to track these changes. The DONC #101 confirmed that resident #001's mattress had been changed from a blue to a purple mattress following the testing on July 11, 2015 and the bed had not been retested. The DONC #101 also confirmed that resident #001 had not been assessed with respect to the use of bed rails. The home recently adopted a Bed Rail Assessment / Decision Tree but they had not yet implemented it.

The severity of this noncompliance was a level three - actual harm/risk. The scope was widespread as it impacted all residents in the home with bed rails. The compliance history was a level two - one or more unrelated noncompliance in the last three years.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that for resident #002 and any other resident exhibiting responsive behaviors, that steps are taken to minimize potentially harmful interactions and the risk of altercations between and among residents, including the following:
(a) Ensuring that residents are screened for their potential or actual risk of harm and if identified they are referred to the appropriate resources.
(b) Identifying factors, based on assessment, observation and information provided to the licensee or staff, that could trigger such potentially harmful interactions
(c) identifying and implement interventions to manage the identified responsive behaviors,
(d) Documenting and communicating the residents' responsive behaviors and any incidents related to those behaviors; and
(e) Providing the appropriate supervision and safety checks to monitor the residents identified at risk.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Documentation review revealed that resident #002 exhibited responsive

behaviors. Interventions identified in the plan of care included redirection from other resident rooms, safety checks when the the resident was not in common areas, and supervision when interacting with peers to ensure safety.

During observations over a 90 minute period resident #002 was not found in their room. A Registered Practical Nurse #104 was asked where the resident could be found. The staff member began a search and found resident #002 in another resident's room. The staff member identified the resident for the inspector and then left the room leaving the resident. Resident #002 was observed to go into four different resident rooms during a fifteen minute period, one of which was their own. Resident #002 exhibited responsive behaviors toward another resident while in one of the rooms. During the more than 90 minutes of observation the inspector did not observe any staff check on resident #002 when they were not in their room and when they were observed exhibiting responsive behaviors toward another resident.

During a second observation period resident #002 was not found in their room or in the common areas of the neighbourhood. Resident #002 was found by an inspector in resident #003's room. Neighbourhood Coordinator (NC) #102 brought resident #002 back out to the hall, opposite to where their room was located, and left them.

During staff interviews with five Personal Care Aides #103, #107, #108, #110, #114 and one Registered Practical Nurse #120 they shared that Resident #002 exhibited responsive behaviors and there had been altercations with other residents.

When staff were asked what strategies and interventions had been put in place to monitor resident #002 and limit conflict with other residents, PCA's #103 and #108 reported that they do their best to monitor resident #002 but it can be challenging while providing care for other residents. When possible they redirect the resident to an appropriate location.

RPN #124 identified specific behaviors that would be documented as incidents. Wandering, voiding in inappropriate locations and any kind of altercation between residents and staff, verbal or physical, that was confirmed by staff as responsive behaviors would be documented as an incident. An incident report would be completed, note left in the communication binder, progress note documented in the electronic record, and referral made to the in house

behavioral support team which was called the Personal Expression Team. The physician would also be notified via the physician log book.

RPN #120 shared that staff had reported conflict / altercations between resident #002 and other residents during shift report. Review of the communication binder / shift report records for the identified neighbourhood revealed one notation of resident #002's responsive behaviors during the last month. The physician had requested an assessment of resident #002's responsive behaviors because of reported conflict with other residents. RPN #118 / lead for the Personal Expression Team confirmed that resident #002 had not been referred to the PE Team.

During an interview with the Administrator #100 and Director of Nursing Care #101 they indicated that it was the home's expectation that safety checks be completed on a regular basis when identified in the plan of care. When asked what time frame safety checks were to be completed the Administrator and DOC indicated that this had not been established in the home and currently the home did not have a system for documenting these checks. The Administrator #100 acknowledged that resident #002 exhibited responsive behaviors which posed a potential risk to other residents, and interventions had not been implemented to minimize the risk of altercations and potentially harmful interactions between resident #002 and other residents.

The severity of this area of noncompliance was a level three - actual harm/risk. The scope was isolated. The compliance history was identified as a level three with one or more related non-compliances in the last three years. A WN/VPC was issued in December 2015 related to this piece of legislation. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall ensure that residents that are dependent on staff for repositioning and /or are at risk of altered skin integrity are repositioned every two hours or more frequently as required, depending upon the resident's condition and tolerance of tissue load.

Grounds / Motifs :

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 and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Record review revealed that resident #001 was to be turned/repositioned in bed every two hours and as needed. The resident had areas of altered skin integrity.

During interviews with three Personal Care Aides (PCA) #114, #103 and #108 they reported that resident #001 was unable to reposition themselves in bed. PCA #114 indicated that on the identified date they had repositioned resident #001 twice on the night shift. PCA #103 shared that because resident #001 slept in they did not provide care until late morning on day shift. PCA's #103 and #114 acknowledged that resident #001 should be repositioned every two hours but indicated that it was impossible given the workload.

The Personal Assistive Service Device (PASD) Repositioning Record for resident #001 over a sixteen day period revealed that there were 5/16 days where the resident was not repositioned for eight hours and 3/16 days where the resident was not repositioned for a period of eighteen hours.

The Administrator #100 and Director of Nursing Care #101 indicated that it was the home's expectation that residents that were dependent in terms of mobility would be repositioned every two hours whether they were in a wheelchair or bed. This would be outlined in the resident's plan of care. The Administrator acknowledged that resident #001 had altered skin integrity and required staff assistance to reposition. They confirmed that the resident had not been repositioned every two hours.

The severity of this noncompliance was a level three - actual harm/risk. The scope was isolated. The compliance history was a level two - one or more unrelated noncompliance in the last three years. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2016

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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