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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2018;	2018_555506_0019 (A1)	011935-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Brierwood Gardens
425 Park Road North BRANTFORD ON N3R 7G5

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

Amended by LESLEY EDWARDS (506) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended because the Licensee requested an extension in the compliance date for 6 (10).

Issued on this 20 day of August 2018 (A1)

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

Original report signed by the inspector.

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Amended by LESLEY EDWARDS (506) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27 and 28, 2018.

During this inspection the inspections listed below were conducted concurrently:

Complaints

031422-16 - related to medications and personal support services

034130-16 - related to abuse and neglect

034368-16 - related to personal support services

001473-17 - related to medications

012043-17 - related to nutrition and hydration, infection control and skin and wound

021705-17 - related to staffing

021707-17 - related to staffing

022816-17 - related to falls management

025895-17 - related to bed safety

008199-18 - related skin and wound and plan of care

Critical Incidents

014917-16 - related to responsive behaviours

020980-16 - related to responsive behaviours

023991-16 - related to responsive behaviours

025126-16 - related to physical abuse

010255-17 - related to personal support services

013151-17 - related to personal support services

013747-17 - related to abuse and neglect

019757-17 - related to falls prevention

020897-17 - related to abuse and neglect

023821-17- related to responsive behaviours

001510-18 - related to abuse and neglect

Follow-up

029353-17 - related to medications

Inquiries

008527-17 - related to responsive behaviours

013411-17 - related to personal support services

027187-17 - related to personal support services

003344-18 - related to abuse and neglect

005883-18 - related to medication administration

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), former ADOC, former DOC, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Recreation Aide, Ward Clerk, Physiotherapist, registered nurses (RNs), registered practical nurses, personal support workers, (PSWs), former Clinical Pharmacist, former pharmacy Manager, former registered staff, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes and dining observations, reviewed clinical records, policies and procedures, the licensee's complaints log, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **2 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
O.Reg 79/10 s. 131. (2)	CO #001	2017_555506_0025	536

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

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

A review of the clinical record stated that resident #001 sustained a fall on an identified date in March 2018. The Falls/Restorative team met on an identified date in March 2018 and confirmed that staff were to encourage the resident to use specified interventions. Interview with the staff on an identified date in June 2018, who is a member of the Falls/Restorative team confirmed that actions and

outcomes in the minutes were to be implemented as a falls prevention intervention and included in the resident's care plan. The resident sustained another fall on an identified date in April 2018. The resident was not using the specified interventions that were to be in place. Progress notes completed by nursing staff at the request of the falls committee on an identified date in April 2018, confirmed the resident was not using the specified interventions. The Falls team had initiated new interventions for the resident to try and prevent falls and these interventions were not put in place as of June 2018, as observed by the Long Term Care Home Inspector (LTCH) and this was confirmed with registered staff #107 on an identified date in June 2018. The plan of care confirmed the resident was at risk for falls but did not include falls prevention interventions. The written plan of care for the resident did not set out the planned care for resident #001 as confirmed with the DOC on an identified date in June 2018. [s. 6. (1) (a)]

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

The plan of care for resident #001 stated they were at risk for falls by the Falls Risk Assessment (FRAT) score. The FRAT score was last updated on an identified date in September 2017 and indicated that the resident was at risk for falls. A physiotherapy assessment completed on an identified date in May 2018, confirmed the resident was at high risk for falls, however, the care plan indicated that the resident was at low risk for falls. An interview with the DOC on an identified date in June 2018, stated staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other in relation to the resident's falls risk. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident #021 as specified in the plan.

The licensee submitted a Critical Incident (CI) to the Director #2678-000007-17 to inform the Director of improper care of resident #021. The plan of care for resident #021 confirmed the resident required physical support to porter the resident in their wheel chair with an intervention applied to their wheel chair. This intervention was initiated on an identified date in June 2017. On another date in June 2017, the resident was being portered to the dining room and sustained a minor injury due to

the intervention not applied to their wheelchair. Interview with registered staff #112 on an identified date in June 2018, confirmed the resident did not have the intervention applied to their wheelchair at the time of the incident and that care set out in the plan of care was not provided to resident #021 as specified in their plan.

The above noted area of non-compliance was identified during a CI inspection, log #013151-17/ CI #2678-000007-17. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in the plan.

Resident #018 had a physician's order to change their medical device as ordered. The licensee submitted a CIS to the Director to inform the Director that registered staff, were not changing the resident's medical device as ordered. A review of the clinical record confirmed the medical device was changed on an identified date in April 2017 and not again until an identified date in May 2017. It was identified that the medical device was changed on an identified date in November 2016 and not again until an identified date in January 2017. The ADOC confirmed in an interview on an identified date in June 2018, that the plan of care was not followed as the resident's medical device was not changed as ordered by the physician.
The above noted area of non-compliance was identified during CI inspection log #010255-17/ CIS #2678-000002-17. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The plan of care for resident #020 in effect since July 2015, stated that the resident was at risk for falls. There were several interventions included in the plan of care for staff to follow as fall prevention strategies for resident #020.

Review of the clinical record identified the following:

i) Resident #020 sustained an unwitnessed fall on an identified date in May 2017, no injuries were noted.
ii) Resident #020 sustained an unwitnessed fall on an identified date in June 2017, no injuries were noted.
iii) Resident #020 sustained an unwitnessed fall on an identified date in June 2017, no injuries were noted.

iv) Resident #020 sustained an unwitnessed fall on an identified date in July 2017, no injuries were noted.
v) Resident #020 sustained an unwitnessed fall on an identified date in August 2017, no injuries noted.
vi) Resident #020 sustained an unwitnessed fall on identified date in August 2017. The resident was complaining pain in two identified areas and the resident was transferred to the hospital and returned with several injuries.

A clinical record review confirmed that the care plan was not revised when the care set out in the plan had not been effective after each of the five falls leading to the fall resulting in several injuries on an identified date in August 2017. In an interview with the DOC on an identified date in June 2018, they confirmed that the resident's falls were discussed at the fall/restorative team meetings; however, no new interventions were put into place. The DOC confirmed resident #020's plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls.
The above non-compliance was identified during a Complaint Inspection log #022816-17. [s. 6. (10) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 planned care for residents is provided as specified in their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Brierwood Gardens is a long term care home with a licensed capacity of 80 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the DOC on an identified date in June 2018.

During an interview on an identified date in June 2018, with the Ward Clerk and DOC they identified that the home did not have a sufficient number of RNs within the staffing plan to fill all the shifts related to staffing events such as sick calls. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with RPNs in combination with the DOC being on call.

The RNs shift times over a 24 hour period were as follows:
Days 0630 to 1430 hrs
Evenings 1430 to 2230 hrs
Nights 2230 to 630 hrs

On an identified date in June 2018, the DOC shared that when they were on call they were sometimes in the building and sometimes off site. It was shared that when they were on call in the building they were working in the capacity of the DOC, and were not considered to be an RN on duty and present in the home.

Two complaints were received in which it was identified that there were RN shortages in September and December 2017. On request the home provided a list of shifts for the month of September and December 2017, May and June 2018, where the RN was not on duty and present in the home.

The following staff provided RN coverage for the identified shifts in September 2017:
- On two dates in September 2017, evening shift, used RPN with day RN on call.
- On two dates in September 2017, evening shift, used RPN for the first 4 hours of the shift with DOC on call.
- On an identified date in September 2017, night shift, used RPN for last 2 hours of shift with DOC on call.

The following staff provided RN coverage for the identified shifts in December 2017:
- On an identified date in December 2017, night shift, used RPN for first 4 hours with DOC on call.
- On three dates in December 2017, night shift, used RPN with DOC on call.
- On an identified date in December 2017, day shift, used RPN with DOC on call.
- On an identified date in December 2017, day shift, for first 4.5 hours DOC on call.

The following staff provided RN coverage for the identified shifts in May 2018:
- On identified dates in May 2018, for day shifts, four used RPNs with DOC on call.
- On identified dates in May 2018, for evening shifts, 11 used RPNs with DOC on call.
- On an identified date in May 2018, for night shift, one used RPN with DOC on call.

The following staff provided RN coverage for the identified shifts in June 2018:
- On identified dates in June 2018, for evening shifts, 11 used RPNs with DOC on call.

It was identified there were 39 shifts where an RPN, with the DOC on call, covered part or all of the RN's shift. The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an

employee of the licensee and was a member of the regular nursing staff on duty and present at all times. (583)
The above non-compliance was identified during Complaint inspection log #021705 -17 and #021707-17. [s. 8. (3)]

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. 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. In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an organized program for each of the interdisciplinary programs under section 48 of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.

Specifically, staff did not comply with the licensee's policies:

A) "Falls Prevention and Injury Reduction", index CARE5-P10 and CARE5-O10.05,

last reviewed on an identified date in March 2018 and confirmed as current in the home by the DOC on an identified date in June 2018. The procedure identified that if the fall was un-witnessed or a resident was witnessed hitting their head during a fall, a Head Injury Routine was to be initiated and Neuro vitals would be monitored for 72 hours.

i) On an identified date in March 2018, resident #001 sustained an unwitnessed fall. The resident was found on the floor and Head Injury Routine was not initiated as confirmed with the DOC on an identified date in June 2018.

B) "Falls Prevention and Injury Reduction", index CARE5-O10.02 dated in July 2016 and confirmed by the DOC on an identified date in June 2018, as the most current at the time of the fall on an identified date in July 2017, identified that upon discovering a resident who had fallen, non-registered staff would not move the resident; they were to call the Nurse immediately and stay with the resident to provide comfort until the nurse arrived. The nurse would complete a thorough head to toe assessment, including all limbs and joints before any transfers took place.

i) Resident #020 sustained an unwitnessed fall on an identified date in July 2017. A PSW staff noted that the resident was on the floor in their room. Review of notes made by registered staff #128 in the risk management program identified that the PSW staff had moved the resident prior to an assessment being completed. Interview with the DOC on an identified date in June 2018 also confirmed that the resident was moved prior to the nurse assessing the resident.

C) "Falls Prevention and Injury Reduction", index CARE5-O10.02 dated in July 2016 and confirmed by the DOC on an identified date in June 2018, as the most current policy at the time of the fall stated that a post fall huddle was to be completed to determine the root cause of any fall. Current plan of care was to be reviewed and updated according to current needs.

i) Interview with the DOC on an identified date in June 2018, confirmed that resident #020 had several falls from May 2017 to August 2017, prior to the fall that resulted in multiple injuries on an identified date in August 2017. A post fall huddle was not documented as having occurred as per policy of the home for the several falls from May 2017 to August 2017. [s. 8. (1) (b)]

2. In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an

organized program for each of the interdisciplinary programs under section 114 (2) of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.

A complaint was received on an identified date in January 2017, at the Ministry of Health and Long Term Care (MOHLTC) Action Line. The complaint alleged that resident #046 was not provided medications for two days resulting in a diagnosis.
A review was completed of resident #046's clinical record including the Electronic Medication Administration Records (EMAR's) and physician's orders. Resident #046 had a specific diagnosis. On an identified date in December 2016, resident #046 developed symptoms. Leading up to an identified date in January 2017, when the resident's symptoms worsened.
According to a progress note on an identified date in January 2017, the resident's physician ordered several medications and tests for the resident to be completed.
Another progress note on an identified date in January 2017, "writer spoke with Substitute Decision Maker (SDM). SDM expressed concern that resident had not received their prescribed medication after being reassured by a nurse that the medication would be initiated today. Writer informed SDM that medication is available in Emergency drug box and should be arriving from pharmacy." On an identified date in January 2017, a progress note stated: "Education provided to resident and SDM regarding medication side effects and adverse effects. Writer offered to start medication this evening or in the morning as per schedule. Resident chose to start medication in the morning."
According to the EMAR's, the medication was not given until a later date in January 2017.
At the time of this inspection the home was no longer using the same pharmacy provider. The Inspector contacted the pharmacy for their policy in place in January 2017, in regards to the Emergency Medication box or Stat box. The policy titled "Satellite Pharmacy Procedure using Point Click Care, policy number: 9.2, effective date: November 2014, revised date: December 2016" confirmed as the policy in place in January 2017, by the Pharmacy Manager #137 stated: "The satellite pharmacy is a local community pharmacy in your area that can be contacted when the Pharmacy is closed and medications are required for a Resident before the next Pharmacy delivery. Procedure: Verify that the Emergency Medication Box does not contain the required medications. The Nurse assesses the situation to determine whether or not the situation is considered to be and emergency or that the Resident requires the medication(s)before the next scheduled Pharmacy delivery."
The Emergency Medication Box List for the home in January 2017, provided by the

Pharmacy Manager #137 identified that the Emergency Medication Box contained two of the medications that were ordered for the resident and the other medication was not available in the Emergency Drug Box for the Registered staff to utilize however, resident #046 had a as necessary (PRN) medication in place.

During interview completed with the ADOC on an identified date in June 2018, they confirmed that it was the expectation of the home that when medications were required, that the Emergency Medication Box would be utilized.

During interview completed with the ADOC on an identified date in July 2018, they confirmed that they could not locate any records that the Satellite Pharmacy had been sent the order on an identified date in January 2017. The Drug Record Book identified that the medications ordered were sent to the home on an identified date in January 2017 by the Pharmacy.

The licensee has failed to ensure that the Pharmacy "Satellite Pharmacy Procedure" policy was complied with.

The above non-compliance was identified during a Complaint inspection log #001473-17. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the resident was protected from abuse by anyone.

Ontario Regulations 79/10 defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident" O. Reg. 79/10, s. 2 (1) (c).

A Critical Incidents System (CIS) report submitted to the MOHLTC on an identified date in August 2016, identified there was an incident between two residents that resulted in an injury. At the time of the inspection resident #009 and #032 were no longer in the home.

A review of documentation in resident #009 and #032's clinical records indicated the following:
On an identified date August 2016, resident #032 was observed wandering around and got up and went to a resident's room and RPN #129 went to resident #009's room. It was observed that resident #032 was sitting and was striking resident #009.

In the Critical Incident (CI) report submitted by the home it was identified that resident #009 had extensive injuries the following day. Resident #009 was assessed by the physician on an identified date in August 2016, and wrote orders.

In an interview with the DOC on an identified date in June 2018, it was confirmed that resident #009 was not protected from physical abuse by resident #032 on an identified date in August 2016. (583).
The above non-compliance was identified during a CIS Inspection log #025126-16. [s. 19. (1)]

2. The licensee failed to ensure that all residents were protected from physical abuse.

O.Reg. 79/10, subsection. 2 (1) of the act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On an identified date in August 2017, the home submitted a Critical Incident Report #2678-000015-18, which indicated that resident #019 was handled roughly by PSW #126 and then had pain in several areas on their body. The resident was upset and wanted the home to call their SDM as they were afraid. The SDM reported that the resident was crying, upset and afraid of this PSW and did not want the PSW looking after them again. During an interview RPN #118 on an identified date in June 2018, confirmed that the resident's mood was different after the incident. On an identified date in June 2018, the ADOC confirmed that the resident was physically abused by PSW #126 as they were handled roughly and the incident caused the resident pain.
The above non-compliance was identified during a CIS Inspection log #019757-17. [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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

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

According to a Complaint that was submitted to the Director on an identified date in April 2018, regarding physiotherapy services for resident #006. A review of the clinical record confirmed that the resident was assessed by the Physiotherapist, however the assessments were not documented in a timely manner and were

entered as late entries. An assessment was conducted on an identified date in March 2018 and was not entered into the clinical record until later in April 2018. Another assessment was completed on an identified date in April 2018 and was not entered into the clinical record until sometime in May 2018. Another assessment was completed on an identified date in April 2018, and was not entered until a later date in May 2018. An assessment was completed on an identified date in April 2018 and was not entered until May 2018. An interview with the DOC on an identified date in June 2018, confirmed that the expectation was that all assessments related to residents were documented in the resident's clinical record at the time of the assessment or shortly after the incident. An interview with the physiotherapist on an identified date in June 2018, confirmed that the assessments were completed but were not documented shortly after the assessment was completed.
The above non-compliance was identified during a Complaint Inspection log #008199-18. [s. 30. (1) 2.]

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

The weekly bathing list for days was reviewed on an identified date in June 2018. The first three residents on the list that were scheduled to have bathing completed on an identified date in June 2018, were reviewed. It was identified under the bathing task that there was no documentation for resident #016 or resident #017 if their bathing intervention was provide as scheduled.

An interview was completed with PSW #116 and #122 and it was shared that resident #016's bath was completed but not documented. PSW #116 followed up with staff who worked on the identified date in June 2018, and it was identified that resident #017 did not receive their bath and that staff did not document that it was not completed or notify staff that it would need to be made up. The home failed to ensure that resident #016 and #017's bathing interventions were documented on their scheduled bath days. (583)
The above non-compliance was identified during a Complaint inspection log #021705-17 [s. 30. (2)]

Additional Required Actions:

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

WN #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 residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On an identified date in June 2018, the home's wound care champion RPN #110 verified that the expectation was that all areas of skin integrity would be assessed weekly and recorded separately for each area of altered skin integrity in the resident's clinical record under the treatment observation record.

Resident #006 had two areas of altered skin integrity. Review of the clinical record for resident #006 confirmed that the weekly wound assessment had not been completed on a weekly basis. The one identified area of altered skin integrity on the resident had been assessed when initially identified on an identified date in May 2018 and again for 12 days and then not completed again until a later date in June 2018. The second area of altered skin integrity on the resident was assessed when initially identified on an identified date in April 2018 and in May of 2018 and then not completed again until later of June 2018. On an identified date in June 2018, RPN #110 confirmed that the weekly skin assessments had not been completed weekly for resident #006.
The above non-compliance was identified during a Complaint Inspection log #008199-18. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #001 was coded as being incontinent on the May 2018, Minimum Data Set (MDS) assessment. The previous MDS assessments completed in February 2018, November 2017 and September 2017, all indicated that the resident was continent. The resident had a change in their continence level and was now occasionally incontinent. Interview with the RAI Coordinator #103 on an identified date in June 2018, confirmed that the resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment specifically designed for assessment of incontinence when the resident's continence level had changed with the MDS coding on an identified date in May 2018.

B) Resident #003 was coded as being continent on the March 2017, MDS assessment. The next MDS assessment completed in May 2018, indicated that the resident had a change in their continence level and now was frequently incontinent. Interview with RAI co-ordinator #103 on an identified date in June 2018, that the resident did not receive an assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment specifically designed for assessment of incontinence when the resident's continence level had changed with the MDS coding in May 2018. (506) [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date in August 2016, an incident involving resident #044 that caused minor injury to resident #043 occurred. A Critical Incident System Report (CIS) was filed by the home to the Ministry of Health and Long Term Care (MOHLTC) Director on an identified date in August 2016.
The former Director of Care (DOC) when interviewed, revealed that at that time in 2016 the on call managers for the home did not always call the after-hours pager on the weekends, resulting in the CIS's not being filed until their return to the office.

When interviewed, Registered Nurse (RN) #109 confirmed that in past they only informed the on call manager after hours and on weekends. They then revealed that the current protocol was for the RN to call the MOHLTC after hours pager, and then a CIS would be completed by the DOC on the next business day.
The home failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

The above non-compliance was identified during a CIS inspection log #023991-16, CIS #2678-000010-16. [s. 24. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #001 sustained a fall on an identified date in February 2018. The clinical record was reviewed and a post fall assessment using a clinically appropriate assessment instrument was not found. Interview with the DOC on an identified date in June 2018, confirmed that a post fall assessment was not completed. [s. 49. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents' Council was responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes and interview with the ED confirmed that not all concerns or recommendations were responded to in writing, to the council within10 days of receipt.

A review of Meeting Minutes did not include written responses for the following concerns identified:
i.During the April 2018, meeting concerns/recommendations were raised related to food preference's. These concerns were responded to during the Residents' Council meeting that was held in May 2018.
ii.During the April 2018, meeting concerns/recommendations were raised related to resident's being disruptive in the dining room. These concerns were responded to during the Residents' Council meeting that was held in May 2018.
iii. During the April 2018, meeting concerns/recommendations were raised related to the Residents would like to see more flowers outside. These concerns were responded to during the Residents' Council meeting that was held May 2018.
It was confirmed by the ED on an identified date in June 2018, that responses to concerns or recommendations from Residents Council were not being completed in writing within 10 days. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that, resident's linens are changed at least once a week and more often as needed.

It was identified through a complaint to the Director that residents are being left in soiled linens. An observation on an identified date in June 2018, identified that resident #013, 014 and 015's bed linens were heavily soiled and stained. On an identified date in June 2018, the DOC came with the LTCH Inspector and observed and confirmed that the three identified resident's linens were stained and soiled. The DOC confirmed that the home had a procedure in place that bed linens are changed once a week or more often as needed and confirmed that the home's procedure was not implemented.
The above noted non-compliance was identified during a complaint inspection log #034130-16. [s. 89. (1) (a) (i)]

Issued on this 20 day of August 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by LESLEY EDWARDS (506) - (A1)

Inspection No. / No de l'inspection : 2018_555506_0019 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 011935-18 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 20, 2018;(A1)

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Brierwood Gardens
425 Park Road North, BRANTFORD, ON, N3R-7G5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debbie Boakes

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

Ministère 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

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

Order / Ordre :

The licensee must be compliant with s. 6 (10) of the LTCHA.

1.The licensee shall ensure that all residents who are at risk of falls and who have sustained falls are reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective in relation to falls prevention.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The plan of care for resident #020 in effect since July 2015, stated that the resident was at risk for falls. There were several interventions included in the plan of care for staff to follow as fall prevention strategies for resident #020.

Review of the clinical record identified the following:

i) Resident #020 sustained an unwitnessed fall on an identified date in May 2017, no injuries were noted.
ii) Resident #020 sustained an unwitnessed fall on an identified date in June 2017, no injuries were noted.
iii) Resident #020 sustained an unwitnessed fall on an identified date in June 2017, no injuries were noted.
iv) Resident #020 sustained an unwitnessed fall on an identified date in July 2017, no injuries were noted.
v) Resident #020 sustained an unwitnessed fall on an identified date in August 2017, no injuries noted.
vi) Resident #020 sustained an unwitnessed fall on identified date in August 2017. The resident was complaining pain in two identified areas and the resident was transferred to the hospital and returned with several injuries.

A clinical record review confirmed that the care plan was not revised when the care set out in the plan had not been effective after each of the five falls leading to the fall resulting in several injuries on an identified date in August 2017. In an interview with the DOC on an identified date in June 2018, they confirmed that the resident's falls were discussed at the fall/restorative team meetings; however, no new interventions were put into place. The DOC confirmed resident #020's plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls.
The above non-compliance was identified during a Complaint Inspection log #022816-17.

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 a level 1 as it related to one resident out of 3 residents reviewed. The home had a level 3 compliance history as they had non-compliance with this section of the LTCHA that included: voluntary plan of correction (VPC) issued November 2017 (2017_555506_0025).

(156)

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

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

Ministère 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

Oct 15, 2018(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically, the licensee must:

1. Review the licensee's access to Registered Nurses (RNs) that are employee's of the licensee and members of the regular nursing staff of the home to ensure there are enough RNs to meet the licensee's staffing needs and allow for absences such as illness and vacation coverage and implement recruitment strategies.

2. Ensure that a RN who is an employee of the home is scheduled to work in the home and on duty and present at all times except as provided for in the regulation.

Grounds / Motifs :

1. The licensee failed to ensure that there was at least one Registered Nurse who

was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Brierwood Gardens is a long term care home with a licensed capacity of 80 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the DOC on an identified date in June 2018.

During an interview on an identified date in June 2018, with the Ward Clerk and DOC they identified that the home did not have a sufficient number of RNs within the staffing plan to fill all the shifts related to staffing events such as sick calls. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with RPNs in combination with the DOC being on call.

The RNs shift times over a 24 hour period were as follows:
Days 0630 to 1430 hrs
Evenings 1430 to 2230 hrs
Nights 2230 to 630 hrs

On an identified date in June 2018, the DOC shared that when they were on call they were sometimes in the building and sometimes off site. It was shared that when they were on call in the building they were working in the capacity of the DOC, and were not considered to be an RN on duty and present in the home.

Two complaints were received in which it was identified that there were RN shortages in September and December 2017. On request the home provided a list of shifts for the month of September and December 2017, May and June 2018, where the RN was not on duty and present in the home.

The following staff provided RN coverage for the identified shifts in September 2017:
- On two dates in September 2017, evening shift, used RPN with day RN on call.
- On two dates in September 2017, evening shift, used RPN for the first 4 hours of the shift with DOC on call.
- On an identified date in September 2017, night shift, used RPN for last 2 hours of shift with DOC on call.

The following staff provided RN coverage for the identified shifts in December 2017:
- On an identified date in December 2017, night shift, used RPN for first 4 hours with DOC on call.
- On three dates in December 2017, night shift, used RPN with DOC on call.
- On an identified date in December 2017, day shift, used RPN with DOC on call.
- On an identified date in December 2017, day shift, for first 4.5 hours DOC on call.

The following staff provided RN coverage for the identified shifts in May 2018:
- On identified dates in May 2018, for day shifts, four used RPNs with DOC on call.
- On identified dates in May 2018, for evening shifts,11 used RPNs with DOC on call.
- On an identified date in May 2018, for night shift, one used RPN with DOC on call.

The following staff provided RN coverage for the identified shifts in June 2018:
- On identified dates in June 2018, for evening shifts,11 used RPNs with DOC on call.

It was identified there were 39 shifts where an RPN, with the DOC on call, covered part or all of the RN's shift. The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times. (583)
The above non-compliance was identified during Complaint inspection log #021705-17 and #021707-17. (583)

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was determined as a level 2 pattern. The home had a level 3 compliance history as they had a related non-compliance in the last three years and were issued a written notification (WN) on June 2, 2016 (2016_205129_0015)

(583)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Oct 31, 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

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

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

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

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

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

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 20 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LESLEY EDWARDS - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton