Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2014	2014_255516_0026	L-000685-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

Berkshire Care Centre
350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4

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

ROCHELLE SPICER (516), ALICIA MARLATT (590), ALISON FALKINGHAM (518), PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 03, 04, 07, 08, 09, 10, 11, 14, 15 and 17, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator and/or Acting Administrators, Director of Care and/or Acting Director of Care, Licensee Vice President of Operations, Director of Training and Development, Pharmacist, RAI Coordinator, Environmental Services Manager, Food Services Manager, Laundry Aides, Housekeeping Aides, Restorative Care Aides, Nurse Clinicians, Registered Nurses, Registered Practical Nurses, Wound Care Nurse, Personal Support Workers, Administrative Staff, and residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident home, dining, common and medication storage areas. Observed resident care provisions, resident-staff interactions, dining services and recreational activities. Relevant resident health care records, home policies, procedures and meeting minutes were reviewed. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

Findings/Faits saillants :

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan related to follow-up treatment post infection. The Acting Director of Care confirmed it was an expectation that physician orders be completed and followed along with any required documentation to confirm that care was in fact provided as ordered.

The licensee failed to ensure there was a written plan of care for each resident that set out:

(c) clear directions to staff and other who provide direct care to the resident

A review of one resident's written plan of care revealed the plan did not provide any direction to the staff regarding this resident's oral care. The Administrator confirmed it was an expectation that the residents plan of care set out clear directions to staff regarding oral hygiene.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The written plan of care for one resident did not reflect preferences related to sleep. The Assistant Director of Care confirmed that it is an expectation that the residents' preferences for sleep are considered when planning and/or providing their overall care routines. [s. 6. (2)] (518)

The licensee failed to ensure that there is a written plan of care for each resident that sets out:

(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

The written plan of care for one resident contained no indication that a PASD was used by the resident. [s. 6. (1) (c)] (518)

The licensee failed to ensure that there was a written plan of care for each resident that sets out:

(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

The written plan of care for one resident did not include any indications related to an intervention being provided for the prevention of skin breakdown.

The Nurse Clinician confirmed this care should have been documented in the plan of care. [s. 6.(1) (c)] (518)

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

Health record review for one resident revealed the directions for treatment of skin impairment did not match on two plan of care documents which were currently in place.

A Registered Nurse confirmed the plan of care for this resident did not set out clear directions to staff and others who provide direct care to the resident. (590)

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. 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 :

Non-registered staff reported and the Administrator confirmed each 35 bed unit had two Personal Support Workers (PSWs) starting their shift at 0600hrs and one PSW starting at 0800hrs. On days that only one PSW came into work at 0600hrs on a unit and the home was not able to replace the other shift; one PSW was responsible to provide morning care to 35 residents.

A review of weekend staffing records for a time period of one month revealed the home was unable to replace staff that could not come into work on several occasions.

The Interim Administrator verified that not replacing Registered and Non-Registered staff who could not come to work had the potential to jeopardize resident care. [s. 31. (3)] (517)

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 :

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

The following home policies were not complied with:

Drug Destruction and Disposal
Resident Weight Monitoring
Male and Female Catheterization
Daily Flow Sheets
Client Service Response Form (Complaint Investigation)

This was confirmed by home management staff members. (517) (590)

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' personal health information was kept confidential in accordance with the Act.

During the initial tour of the home, the "archived residents records room" in the basement home area was found by an inspector to be unlocked and unattended by staff . This home area is accessible to residents, staff and visitors.

The Director of Care confirmed the archived residents records room was unlocked and unattended by staff. The Director of Care further confirmed that the records room should be kept locked at all times when unattended to secure the confidentiality of resident records. [s. 3. (1) 11. iv.] (518)

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 for ensuring resident personal health records are securely kept confidential, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with.

The homes policy "RCS E-25 Resident Safety Restraints" indicated that a least restraint alternatives assessment must be completed prior to the application of a PASD and quarterly.

Review of one resident's health record revealed the use of a PASD, however, there was no documentation to indicate a least restraint alternatives assessment was completed in the computer under this residents assessments or in the paper chart for this resident.

The Acting Director of Care confirmed it was an expectation that all of the homes policies be followed, including, documenting resident least restraints alternatives assessments. (518)

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 with ensuring the policy to minimize restraining residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (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 :

The licensee confirmed they were unable to locate the written record for the Continence Program for 2013. (516)

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 are documented.

Review of one resident's treatment administration record revealed 8 out of 15 (53%) of required interventions were not documented in one month; 10 out of 15 (67%) of required interventions were not documented in another month; and 2 required interventions were not documented in the current month. The Nurse Clinician confirmed it was an expectation that any interventions provided to a resident are documented once this care is provided. (518)

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 are documented.

Health record review for one resident revealed interventions being provided once a month were not documented on four occasions. Health record review for this same resident revealed interventions being provided once a week were not documented on five occasions. The Assistant Director of Care confirmed the expectation was that all care was to be documented in the resident health record once that care had been provided. (518)

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

Health record review for one resident indicated interventions were to be provided once a month. Health record documents revealed these interventions were not documented on two occasions. A Registered Nurse confirmed the interventions provided to this resident should have been documented. (590)

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 with ensuring that

1) a written record relating to each program evaluation including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented is kept

2) any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

Five residents with various oral health concerns did not receive an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

The Director of Care and Social Worker were unable to verify that these five residents received an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. The Director of Care confirmed it was an expectation that all residents receive an offer of an annual dental examination.

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 each resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #8: 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 :

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Health record review for one resident indicated interventions for the use of pressure relieving devices for skin integrity management. During the Resident Quality Inspection, the resident was observed without pressure relieving devices in use. A registered staff member confirmed the home had pressure relieving devices available and that this resident should have had pressure relieving devices in use. (590)

The licensee failed to ensure that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

Health record review for one resident indicated the resident had altered skin integrity. The inspector was unable to locate a registered dietitian assessment in the residents' health record. A registered dietitian confirmed they had not received a referral and therefore had not completed a dietary assessment related to the altered skin integrity for this resident. (516)

The licensee failed to ensure a resident exhibiting altered skin integrity, including skin

breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Health record review for one resident revealed interventions in place for the care and treatment of altered skin integrity. The homes Skin Care and Wound Management Program indicated that weekly skin and wound summaries were to be completed and documented. A registered staff member was unable to produce documentation supporting that weekly wound assessments were completed for this resident. (590)

The licensee failed to ensure a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, if clinically indicated.

Registered and non-registered staff confirmed one resident had altered skin integrity for over six months and had not received weekly skin assessments from April to July, 2014. Review of the health record for this resident revealed skin assessments were not completed or documented for this resident from April to July 18, 2014. The Interim Administrator verified that residents exhibiting altered skin integrity were to receive a skin assessment by a member of the registered staff weekly and that the skin assessments were to be documented in the resident's health record. (517)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:

1)receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required
2)are reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, if clinically indicated, and
3) are assessed by a registered dietitian who was a member of the staff of the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

The licensee failed to ensure that measures to prevent transmission of infections to others were put in place.

Health record review for one resident indicated the home was informed of this resident having a positive MRSA infection result. The homes established infection control practices to prevent the transmission of MRSA infections to others were not instituted until the home was alerted by the inspector that these measures had not been put into place. This was confirmed by the Assistant Director of Care. (516)

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 measures to prevent the transmission of infections are implemented and complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and kept inaccessible to residents at all times.

During the initial Resident Quality Inspection tour of the home, it was confirmed that storage rooms in the basement home area were accessible to the residents. During the tour, a storage room in the basement home area which contained multiple hazardous substances including an unlabelled vat of fluid was found unlocked and unattended.

The Director of Care and the Maintenance Supervisor confirmed the unlocked, unattended storage room containing multiple hazardous substances and verified that this room should have been locked. Further, the Director of Care and the Maintenance Supervisor confirmed all chemical storage containers should be properly labelled. [s. 91.] (518)

2. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

During the initial Resident Quality Inspection tour of the home, the cabinet below the fish tank on the main floor was observed to contain tank cleaning products and a medication labelled for "sick fish".

The Director of Care viewed this cabinet with the inspector and confirmed this cabinet containing hazardous substances was unlocked, unattended and accessible to the residents. [s. 91.] (518)

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 hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act:

"That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)"

One resident who required repositioning every two hours was not repositioned and/or the repositioning was not documented as required. This was confirmed by a Registered Staff Member and the Acting Director of Care. (518)

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 for ensuring the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself) and that every release of the device and all repositioning are documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee failed to ensure that drugs stored in a medication cart were kept secure and locked.

An inspector was able to open an unsupervised medication cart and visualize resident medications. The Director of Operational Services confirmed it was the homes expectation that medication carts are kept locked while unsupervised. (590)

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 drugs stored in a medication cart are kept secure and locked, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

The licensee failed to ensure that when a non-controlled drug that was destroyed, that this was done by a team acting together and composed of:

i. one member of the registered staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing, as evidenced by:

The Nursing Clinician and Assistant Director of Care confirmed these drugs were not denatured to such an extent that their consumption was rendered impossible or improbable before leaving the building. In addition to this, the Nursing Clinician and Assistant Director of Care verified that these non-controlled drugs had not been destroyed by one member of the registered nursing staff and one other staff member who were appointed by the Director of Nursing. (517)

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 for ensuring that all non-controlled drugs are destroyed by a team acting together and composed of, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

The licensee failed to ensure that all direct care staff were provided training in skin and wound care.

A review of the homes Skin and Wound Care education program for 2013, revealed that only 86% of direct care staff had received training in skin and wound care. This was confirmed by the Director of Training and Development. (590)

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 skin and wound care training is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee failed to ensure that all staff participated in the implementation of the infection control and prevention program.

1) One resident's urinary catheter bag was found sitting directly on the floor. A Registered Practical Nurse staff member confirmed the resident's catheter bag should not have been sitting directly on the floor in accordance with the homes established infection control practices. The Director of Care further confirmed this was an infection control risk and that the catheter bag should not have been on the floor. (516)

2) Medication administration observation revealed the policy and procedure for the administration of non-cytotoxic hazardous medications, as part of the infection prevention and control program, was not followed.

The Nursing Clinician, Director of Care and Assistant Director of Care verified the policy and procedure for the administration of non-cytotoxic hazardous medications, as part of the infection prevention and control program, was not followed. (517)

3) Medication administration observation for one resident by an inspector revealed the staff member did not perform hand hygiene before administering the medication to this resident.

The Director of Care, Assistant Director of Care and Nursing Consultant revealed the expectation was that the staff performed hand hygiene before administering medications to a resident. (517)

4) The licensee failed to ensure that the following immunization and screening

measures were in place:

Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Health record review for one resident indicated this resident refused admission TB skin testing due to an allergic skin reaction. Where a skin test cannot be done, a chest x-ray can be done. There were no follow up orders for a chest x-ray and no chest x-ray results in this residents health care record.

The Assistant Director of Care confirms this resident had not been screened for TB prior to admission to the home or since being admitted to the home that it is the expectation that all residents are screened for TB on admission. (518)

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:

1)all staff participate in the implementation of the infection and control program

2)each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

The licensee failed to ensure that a written record was maintained for each resident of the home.

During review of one resident's health record documentation, it was noted that the resident flow sheet did not have any of the required documentation on page 2 and 3, for four shifts. The Nurse Clinician confirmed the expectation was that the flow sheets have the required documentation for all shifts and that if care was not provided for any reason, this should be documented rather than leaving the form with no documentation. The Nurse Clinician further confirmed the residents' record was not maintained per the homes established documentation practices. (516)

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 a written record is consistently maintained for each resident of the home, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure the home was a safe and secure environment for its residents.

During the initial Resident Quality Inspection home tour, an inspector noted that an elevator area had two unlocked, unattended, electrical panels that a resident could access.

This was confirmed by the Director of Care and the Maintenance Supervisor who shared that the unlocked, unattended, electrical panels posed a safety risk to residents and should have been locked. [s. 5.](518)

2. An inspector did a walk around on a home unit at 0910hrs and 0945hrs. Upon arrival to the unit at 0945hrs there was a distinct smell of something burning. Further inspection revealed the staff had left the warming table on in the dining room with two empty coffee pots inside. All the water in the warming table and coffee in the coffee pots had evaporated and that was the source of the burning smell.

Personal Support Workers interviewed reported the expectation was that the staff turn off the warming table after breakfast and this had not been done that day.

The interim Administrator verified staff members were responsible to turn off the warming table after breakfast. The interim Administrator further verified leaving the coffee pots on the warming table with no coffee in them was a safety concern for the residents on the unit. [s. 5.](517)

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas which are equipped with locks to restrict unsupervised access to those areas by residents were kept closed and locked when they were not being supervised by staff.

An inspector was able to access the laundry chutes on two resident care areas. A Personal Support Worker for each of these care areas confirmed that the laundry chute door should have been locked and inaccessible to residents. [s. 9. (1) 2.](590)

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During the Resident Quality Inspection, an inspector observed one resident, alone in their room, who did not have their call bell within reach. A Restorative Care Aide and the Director of Operational Services confirmed this resident's call bell should have been within reach. (590)

The licensee failed to ensure that the home was equipped with a resident-staff communication system that could be easily seen, accessed and used by residents, staff and visitors at all times.

The bathroom call bell in one resident ward room was inspected with the Environmental Services Manager present. The Environmental Services Manager confirmed the bathroom call bell was missing the pull cord, that this had not been reported missing and that the pull cord should have been in place. (516)

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's Abuse and Neglect policy states:

"On becoming aware of abuse or neglect or suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Director of Nursing/or Delegate or if not available, the Administrator".

An incident of alleged resident to resident abuse was not reported to the Director of Nursing or Delegate or Administrator by the staff member first having knowledge of the alleged abuse. The Director of Care, Nursing Consultant and Assistant Director of Care verified the expectation was that the staff member first having knowledge of alleged abuse must report it immediately to the Director of Nursing, the Assistant Director of Nursing, the Manager on call or the Administrator. (517)

WN #21: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee had failed to ensure a resident plan of care was based on, at a minimum, interdisciplinary assessment of the resident's dental and oral status including oral hygiene.

A resident's plan of care was reviewed. The Inspector was unable to locate a plan of care in relation to oral hygiene for this resident. The Assistant Director of Care further confirmed the resident did not have a plan of care for oral hygiene. (516)

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The home's Abuse or Neglect policy, states:

"The police shall be notified by the Administrator or designate of any alleged, suspected, witnessed incident of abuse or neglect of a resident as soon as the Administrator or designate suspects the actions may be a criminal offence".

The police were not notified immediately of alleged resident to resident abuse. The Nursing Consultant verified the expectation was that the appropriate police force should be immediately notified of all alleged resident abuse. (517)

Issued on this 19th day of September, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROCHELLE SPICER (516), ALICIA MARLATT (590), ALISON FALKINGHAM (518), PATRICIA VENTURA (517)
Inspection No. / No de l'inspection :	2014_255516_0026
Log No. / Registre no:	L-000685-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 18, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	Berkshire Care Centre 350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELIZABETH DESJARLAIS-TEFFT

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving and ensuring on-going compliance with LTCHA, 2007 S.O. 2007, c.8, s. 6.

The plan must include how the licensee will ensure compliance with the following:

There is a written plan of care for each resident that sets out:

a) the planned care for the resident
b) the goals the care is intended to achieve and;
c) clear directions to staff and other who provide direct care to the resident

LTCHA, 2007 S.O. 2007, c.8, s.6(1) (a) (b) (c)

The plan of care is based on:

a) the needs and preferences of the resident

LTCHA, 2007 S.O. 2007, c.8, s.6 (2)

The care set out in the plan of care:

a) is provided to the resident as specified in the plan

LTCHA, 2007 S.O. 2007, c.8, s.6 (7)

The plan must identify how and when, the licensee will educate all staff who provide direct care to the residents, on LTCHA, 2007 S.O. 2007, c.8, s.6(1) (a) (b) (c), LTCHA, 2007 S.O. 2007, c.8, s.6 (2) and LTCHA, 2007 S.O. 2007, c.8, s.6 (7).

The plan must also include how compliance will be monitored on an on-going basis and who will be responsible for the monitoring both in the short term and long term.

Please submit the plan in writing to Rochelle Spicer, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance and Improvement Branch, 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2, by November 14, 2014.

Grounds / Motifs :

1. Previous inspections have identified on-going non-compliance with WN and/or VPC's being issued on the following dates:

November 22, 2012 – s.6(1)(a)
August 20, 2013 – s.6(1)(c) and s.6(7)
December 19, 2013 – s.6.(7)
January 16 and 17, 2014 – s.6(7)
May 12, 2014 – s.6(1)
May 26, 2014 – s.6(7)

During the home's Resident Quality Inspection for 2014, the following non-compliance was noted:

1) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to follow-up treatment post urinary tract infection. The Acting Director of Care confirmed it was the homes expectation that physician orders be completed and followed along with any required documentation to confirm that care was in fact provided as ordered.

2) The licensee failed to ensure there was a written plan of care for each resident that set out:

(c) clear directions to staff and other who provide direct care to the resident

A review of one resident's written plan of care revealed the plan did not provide any direction to the staff regarding this resident's oral care. The Administrator confirmed it was an expectation that the residents plan of care set out clear directions to staff regarding oral hygiene. (518)

4) The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The written plan of care for one resident did not reflect preferences related to sleep. The Assistant Director of Care confirmed that it is an expectation that the residents' preferences for sleep are considered when planning and/or providing

their overall care routines. [s. 6. (2)] (518)

5) The licensee failed to ensure that there is a written plan of care for each resident that sets out:

(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

The written plan of care for one resident contained no indication that a PASD was used by the resident. [s. 6. (1) (c)] (518)

6) The licensee failed to ensure that there was a written plan of care for each resident that sets out:

(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

The written plan of care for one resident did not include any indications related to an intervention being provided for the prevention of skin breakdown. The Nurse Clinician confirmed this care should have been documented in the plan of care. [s. 6.(1) (c)] (518)

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

Health record review for one resident revealed the directions for treatment of skin impairment did not match on two plan of care documents which were currently in place. A Registered Nurse confirmed the plan of care for this resident did not set out clear directions to staff and others who provide direct care to the resident.

(518)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

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. 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Order / Ordre :

The licensee must ensure that the staffing plan includes an effective 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.

Grounds / Motifs :

1. Non-registered staff reported and the Administrator confirmed each 35 bed unit had two Personal Support Workers (PSWs) starting their shift at 0600hrs and one PSW starting at 0800hrs. On days that only one PSW came into work at 0600hrs on a unit and the home was not able to replace the other shift; one PSW was responsible to provide morning care to 35 residents.

A review of weekend staffing records for a time period of one month revealed the home was unable to replace staff that could not come into work on several occasions.

The Interim Administrator verified that not replacing Registered and Non-Registered staff who could not come to work had the potential to jeopardize resident care. [s. 31. (3)] (517)
(517)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving and ensuring on-going compliance with O.Reg 79/10, s. 8. (1) (b):

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; that it is complied with.

Specifically, the plan must indicate how the licensee will achieve and ensure on-going compliance with the following policies:

• Drug Destruction and Disposal, Index ID:RCS F-35
• Resident Weight Monitoring
• Male and Female Catheterization Index ID B-05
• Daily Flow Sheets policy #RCS C-50
• Client Service Response Form (Complaint Investigation) LGM I-10

Education on all the above policies must be completed for all registered staff.

Education on Resident Weight Monitoring, Male and Female Catheterization Index ID B-05, and Daily Flow Sheets #RCS C-50 policies must be completed with all staff who provide direct care to the residents.

Education on Client Service Response Form (Complaint Investigation) LGM I-10 must be completed with all home staff.

The plan must indicate when and how staff education will occur including record keeping of this education.

The plan must indicate how compliance will be monitored on an on-going basis and who will be responsible for the monitoring to ensure all policies are complied with.

Please submit the plan in writing to Rochelle Spicer, Long-Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London ON, N6A 5R2, by November 14, 2014.

Grounds / Motifs :

1. Previous inspections on the following dates have identified on-going non-compliance with WN and/or VPC's being issued in relation to policies not being complied with:

March 26 and April 23, 2014
March 25, 2014
February 04, 2014
January 16 and 17, 2014
December 23, 2013
April 30, 2013
November 28, 2011 during the homes last Resident Quality Inspection

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

The following home policies were not complied with:

Drug Destruction and Disposal
Resident Weight Monitoring
Male and Female Catheterization
Daily Flow Sheets
Client Service Response Form (Complaint Investigation)

This was confirmed by home management staff members.

(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rochelle Spicer

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