Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 26, 30, 31, Nov 1, 2, 5, 6, 7, 8, 9, 2012	2012_196157_0006	Complaint

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

WINBOURNE PARK
1020 Westney Road North, AJAX, ON, L1T-4K6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the licensee's Administrator, Director of Care (DOC), registered nursing staff and residents.

During the course of the inspection, the inspector(s) reviewed the clinical health records of two identified residents, reviewed the home's policies related to Restraints, Falls Interventions Risk Management, Pain Assessment and Symptom Management, Management of Concerns and Complaints, Resident Abuse and Neglect, observed the provision of resident care and services.

Two complaint inspections were completed during this inspection. (Log #000135-12, 000781-12)

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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
Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6.(2), 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 the resident:

Facility policy, Pain Assessment and Symptom Management, LTC-N-60-ON, revised August 2010 states that all residents will be assessed for pain and consistently and systematically monitored for pain, using a quick pain assessment (PQRST) and where necessary, a thorough assessment will be completed using one or more pain assessment instruments provided.
Resident #02 had a diagnosis which could result in pain. Family members expressed that the resident was demonstrating non verbal signs of pain.. There is no evidence that a pain assessment was completed using a clinically appropriate assessment instrument as defined in the facility's policy.[s.6.(2)] (Log #000781)

Progress notes for resident #01 indicate that the resident complained of pain since experiencing a fall. The resident had an xray which indicated a need for further assessment. There is no evidence of further assessment or action taken in response to this xray report. There is no indication of interventions to assess or manage the resident's expressed pain related to this injury.[s.6.(2)] (Log #000135-12)

When resident #01 was admitted to the home, pre-admission information from the CCAC advised the home that the resident experienced mild pain. There is no evidence that a pain assessment was completed for this resident as required by facility policy.
Resident #01 was readmitted to the home following hospitalization. Hospital records indicate the resident was receiving pain management interventions. The resident's physician ordered a medication for pain management. Records indicate that only one dose of this medication was administered. An entry in the resident's Plan of Care identifies the resident was experiencing pain. There is no evidence that a pain assessment was completed for the resident. There is no clear direction provided in the resident's plan of care related to pain assessment or management.[s.6.(2), s. 6.(1)(c)] (Log #000135-12)

Resident #01 was admitted to the home with a diagnosis which required the administration of a medication. This medication was not continued at the time of the resident's admission to the home and staff acknowledge that it was missed in error in the medication reconciliation when the resident was admitted. Blood work completed post admission identified abnormal results related to this condition. There is no evidence that the resident's lab results were assessed or that any action was taken in response to the results. The resident's family reported the resident's need for this medication and it was subsequently ordered by the physician. [s.6.(2)](Log #000135-12)

The care set out in the plan of care for resident #01 and #02 was not based on an assessment of the resident and the needs and preferences.

2. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7) to ensure that the care set out in the plan was provided to the resident as specified in the plan:

A physician's order was received to schedule a diagnostic test for resident #02 in response to family concerns. Two weeks later the resident's family inquired about the date for the test and was advised it had not yet been scheduled.The test was conducted 5 1/2 weeks after it was ordered by the physician. The resident's family was not able to access results of the diagnostic test and as a result had to contact the hospital to follow up on the outcome. [s.6.(7)] (Log #000781-12)

The physician for Resident #02 ordered the administration of a medication with direction for administration related to an identified evaluation of the resident's status. Tracking records for resident #02 indicate that this evaluation was not completed on 18 occasions over the course of three identified months. [s.6.(7)] (Log #000781-12)

Physician's orders for Resident #02 direct the administration of a medication. Progress notes indicate that the medication was not administered as ordered on two occasions without appropriate direction in the plan of care for withholding the medication and without consultation with the physician.
[s.6.(7)] (Log #000781-12)

On an identified date resident #01 was found lying on the floor. The resident complained of pain and was transferred to hospital. The resident's subsequent death was identified by the coroner as being a result of complications of the fall. The resident's plan of care directed specific interventions to be in place for fall prevention. Staff confirm that these interventions were not in place at the time of the fall. [s.6.(7)] (Log #000135-12)

The care set out in the plan was not provided to resident #01 and #02 as specified in the plan.

3. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6.(1)(c) to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident:

The plan of care for resident #01 does not provide direction to staff related to skin care assessment and monitoring following hospitalization. [s.6.(1)(c)] (Log #000135-12)

Resident #02 received a medication related to a medical diagnosis four times a day. The residents written plan of care fails to provide direction for required protocols related to the administration of this medication.[s.6.(1)(c)] (Log #000781-12)

The written plans of care for resident #01 and #02 fails to set out directions to staff and others who provide direct care to the resident.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3.(1)1. to ensure that every resident's right to be treated with courtesy and respect,in a way which fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.
Progress notes for resident #01 indicate a significant delay in transfer of the resident at the time of death. The home was not able to explain the reason for delay in transferring the resident. The clinical record fails to clearly indicate a time of death and does not indicate when the body was released and to whom. The resident's right to be treated with dignity was not respected. [s.3.(1)1.](Log #000135-12)

On an identified date resident #01's son visited and found the resident inappropriately clothed. A complaint was made to the Director of Care and an investigation confirmed that staff had left the resident partially clothed. The resident's right to be treated with respect and dignity was not respected. [s.3.(1)1.](Log #000135-12)

2. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3.(1)11.i.,ii. to ensure that every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care and to give or refuse consent to any treatment care or service.
Progress notes indicate that when resident #01 was admitted to the home the POA's request to have a medication discontinued was refused by the physician. [s.3.(1)11.i, ii] (Log #000135-12)

Resident #01's right to participate fully in the development, implementation, review and revision of her plan of care and to give or refuse consent to any treatment care or service was not fully respected and promoted.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident's right to be treated with respect in a way that fully recognizes the resident's dignity and that each resident's right to participate in the development of his or her plan of care and give or refuse consent to any treatment is fully respected and promoted, to be implemented voluntarily.

WN #3: 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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. In accordance with the requirements of the LTCHA, 2007, S.O. 2007, c.8, s. 20(2)(d) The Licensee's 's policy to promote zero tolerance of abuse and neglect of residents, policy LP-B-10 "Management of Concerns/Complaints/Compliments", revised October 2011, fails to meet the requirements of LTCHA, 2007, S.O. 2007, c.8, s. 20(2)(d), in that it does not contain an explanation of the duty under section 24 to make mandatory reports to the Director.[s.20.(2)(d)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 50.(2)(a)(ii) by failing to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon the resident's return from hospital:

A Head to Toe Skin Assessment of resident #01 on return from hospital is incomplete and does not identify post surgery care and monitoring needs. [s.50(2)(a)(ii)] (Log #000135-12)

A resident at risk of altered skin integrity did not receive a thorough skin assessment by a member of the registered nursing staff upon the resident's return from hospital.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 24.(4) by failing to ensure that the care set out in the admission plan of care is based on an assessment of resident #01 and the needs and preferences of that resident and on the assessment information provided by the the placement coordinator:

Assessment information received from the placement co-ordinator, identifies the following related to care needs and preferences for resident #01:
- Memory and decision making impairments are not incorporated into the resident Admission Plan of Care
- Vision impairment is not incorporated into the Admission Plan of Care
- The resident's history of frequent falls and risk for falls is not identified on the Admission Plan of Care
- Continence status is not accurately recorded the Admission Plan of Care
- The resident's pain status is not accurately recorded on the Admission Plan of Care
- The resident's skin condition is not accurately recorded on the Admission Plan of Care. [s.24.(4)] (Log #000135-12)

The care set out in the admission plan of care for resident #01 is not based on an assessment of the resident and the needs and preferences of that resident and on the assessment information provided by the the placement coordinator.

2. The licensee failed to comply with O.Reg. 79/10, s. 24.(3)(a)(b) by failing to ensure that the admission plan of care sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident:

The "Resident Admission Assessment/Plan of Care" for resident #01 fails to set out the planned care for the resident and fails to provide clear direction to staff and others who provide direct care to the resident related to the following:
- the care required for physical functioning
- the care required for personal hygiene
- the type and frequency of foot care required
- direction for continence care required
- clear direction for actions to facilitate safe transfers
- fails to identify a reason for a physiotherapy referral [s.24.(3)(a)(b)](Log #000135-12)

The admission plan of care for resident #01 fails to set out the planned care for the resident and provide clear directions to staff and others who provide direct care to the resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the Admission Plan of Care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 24.(1)2. by failing to ensure that a person who has reasonable grounds to suspect that neglect of a resident has occurred, has immediately reported the suspicion and the information upon which is based, to the Director:
The licensee was made aware of allegations of neglect of resident #01 on two occasions. The allegations were investigated and substantiated by the facility.
These allegations of neglect were not immediately reported to the Director.[s.24.(1)2.] (Log #000135-12)

Issued on this 15th day of November, 2012

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

Ministry of Health and Long-Term Care

Ministére 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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA POWERS (157)
Inspection No. / No de l'inspection :	2012_196157_0006
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Oct 26, 30, 31, Nov 1, 2, 5, 6, 7, 8, 9, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	WINBOURNE PARK 1020 Westney Road North, AJAX, ON, L1T-4K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BEVERLEY RAYSIDE

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 : 901

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

Order / Ordre :

The licensee shall prepare, implement and submit a plan to ensure that care related to falls prevention, monitoring of blood sugars and scheduling of diagnostic tests/evaluation, as set out in the plan of care, is provided to the resident as specified in the plan.
Written plan is to be submitted to MOHLTC Attention: Pat Powers Fax #613-569-9670 by November 30, 2012.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7) to ensure that the care set out in the plan was provided to the resident as specified in the plan:

A physician's order was received to schedule a diagnostic test for resident #02 in response to family concerns. Two weeks later the resident's family inquired about the date for the test and was advised it had not yet been scheduled.The test was conducted 5 1/2 weeks after it was ordered by the physician. The resident's family was not able to access results of the diagnostic test and as a result had to contact the hospital to follow up on the outcome. [s.6.(7)] (Log #000781-12)

The physician for Resident #02 ordered the administration of a medication with direction for administration related to an identified evaluation of the resident's status. Tracking records for resident #02 indicate that this evaluation was not completed on 18 occasions over the course of three identified months. [s.6.(7)] (Log #000781 -12)

Physician's orders for Resident #02 direct the administration of a medication. Progress notes indicate that the medication was not administered as ordered on two occasions without appropriate direction in the plan of care for withholding the medication and without consultation with the physician.
[s.6.(7)] (Log #000781-12)

On an identified date resident #01 was found lying on the floor. The resident complained of pain and was transferred to hospital. The resident's subsequent death was identified by the coroner as being a result of complications of the fall.
The resident's plan of care directed specific interventions to be in place for fall prevention. Staff confirm that these interventions were not in place at the time of the fall. [s.6.(7)] (Log #000135-12)

The care set out in the plan was not provided to resident #01 and #02 as specified in the plan. (157)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Ministry of Health and Long-Term Care

Ministére 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

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
Toronto ON M5S 2B1
Télécopieur: (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
Toronto ON M5S 2B1
Télécopieur: (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 9th day of November, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PATRICIA POWERS

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