Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 01, 2016;	2015_275536_0019 (A2)	H-003433-15	Resident Quality Inspection

Licensee/Titulaire de permis

YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE SCARBOROUGH ON M1V 5L3

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

YEE HONG CENTRE - MISSISSAUGA
5510 Mavis Road MISSISSAUGA ON L5V 2X5

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

CATHIE ROBITAILLE (536) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order. The Director's review was completed on 2016-01-15. Order were altered to reflect the Director's review.

Issued on this 1 day of February 2016 (A2)

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

Original report signed by the inspector.

Ontario

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CATHIE ROBITAILLE (536) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 26, 27, 28, 29, 30,November 3, 4, 5 and 6, 2015

During this Resident Quality Inspection(RQI), Complaint Inspection and Critical Incident System (CIS)Inspection Log#005624-15 were conducted concurrently. There were findings of non-compliance in the Complaint inspection. The following Inspection Protocols were completed in relation to this log #: Falls Prevention and Skin and Wounds.

During the course of the inspection, the inspector(s) spoke with residents, family members, dietary staff, Food Services Manager(FSM), Registered Dietitian (RD),Personal Support Workers (PSW's),Registered Staff,Facility Manager, housekeeping staff, Assistant Director of Resident Care (ADRC), Director of Resident Care(DORC) and the Executive Director(s).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #046.

On an identified date and time; resident #046 fell, resulting in injuries. The investigation notes; as well as the Director of Resident Care (DORC) and PSW #110, identified that PSW #113 at the time of the fall had their back turned away from the resident. As a result of the fall, the resident suffered significant injuries. The home failed to ensure that staff use safe transferring and positioning techniques when assisting resident #046. [s. 36.]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A) A review of resident #030's Resident Assessment Instrument (RAI)Material Data Set(MDS) Assessment completed on an identified date, indicated that they required extensive assistance. An interview with Personal Support Worker (PSW)#101 indicated, that resident #030 was instructed not to transfer independently for toileting, as they were at risk for falling. However, the resident and their family stated that the resident seemed more able to transfer independently for toileting. A review of the document the home referred to as their care plan completed on an identified date, did not set out clear direction to staff and others.

During interview, the Assistant Director of Resident Care (ADRC) confirmed that staff had unclear directions regarding the assistance required for transferring and toileting for resident #037.

B) A review of resident #028's RAI MDS assessment completed on an identified date, indicated that they were frequently incontinent.

During interview, PSW's #102, #107, and #108 confirmed the resident was frequently incontinent. A review of the document the home referred to as the resident's care plan

for incontinence, which directed staff to directed staff to provide different interventions for resident #028.

C) Resident #028 was observed by an identified date, PSW #107 reviewed resident #028's care plan; and confirmed, that it did not give staff clear direction for resident #028. The ADRC confirmed, that residents' written plan of care should direct staff regarding approaches; frequency and timing of toileting for residents, in order to provide clear directions to direct care staff.

D) On an identified date and time, resident #046 had a fall resulting in injuries which resulted in resident being less independent in regards to mobilization. The document the home refers to as the care plan for resident #046 was reviewed. The care plan identified that resident #046 identified interventions that had previously been in place prior to the fall. The plan of care did not set out clear direction for staff and others. This was confirmed by the Director of Resident Care (DORC) on November 6, 2015. [s. 6. (1) (c)]

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

A) A review of resident #037's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed on an identified date, indicated that the resident was occasionally incontinent. Health records also indicated, that the resident wore a brief for incontinence. The document the home referred to as the care plan indicated that the resident was occasionally incontinent and wore an continence brief.

During interview, PSW #100 and the Assistant Director of Resident Care (ADRC) who also oversaw the home's continence management program; stated, that the resident was not incontinent and did not wear briefs. The ADRC responsible for Resident Assessment Inventory (RAI) confirmed that resident #037's Resident Assessment Instrument (RAI)assessments were not consistent with direct care staff assessments or observations, and the plan of care had not been updated to reflect the resident's continence level,or that they did not wear continence briefs.

B) On an identified date, resident #047 was observed in the dining room during lunch receiving full assistance from staff to eat their meal.

i) Review of the resident's most recent Minimum Data Set (MDS) Assessment,

completed on an identified date, indicated the resident required extensive assistance with eating.
ii) Interview with PSW #106 confirmed the resident required extensive assistance from a staff member to feed them at all meals.
iii) The resident's current documented plan of care indicated the resident only required limited assistance with eating. Interview with the Registered Dietitian (RD) confirmed the resident required limited assistance, as at times they could feed themselves but at other times could not.

The RD confirmed that the resident's documented plan of care did not reflect the resident's current needs identified by nursing staff. The staff did not collaborate with each other in the assessment of resident #047 so that their assessments were integrated and consistent with and complemented each other. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the plan of care sets out clear directions to staff and others who provided direct care to the resident and that those individuals involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #046 who was dependent on staff was repositioned every two hours.

The document the home refers to as the care plan for resident #046, specified that the resident was to be re-positioned every 2 to 3 hours by 2 staff. A review was completed, of the Point of Care (POC) turning and repositioning schedule for identified dates, for resident #046. Between identified dates, there were a number of incidents, were the documentation identified longer than 2 hours, between turning and repositioning times for resident #046. This was confirmed by the Director of Resident Care on November 6, 2015. [s. 50. (2) (d)]

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 and ensuring that resident #046 who was dependent on staff was repositioned every two hours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that, (e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

During interview, the Assistant Director of Resident Care (ADRC) stated that the home's expectation is that residents' continence should be assessed on admission, readmission and when there was a significant change in status.

A) According to clinical records, resident #030 sustained falls on on identified dates, causing injury. Following the fall. the resident's ability to transfer, as well as their continence level deteriorated. A review of clinical records indicated, that the resident's continence was not assessed for identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. The ADRC confirmed that resident #030's continence had not been assessed after these falls and significant change in condition.

B) A review of resident #028's Resident Assessment Instrument (RAI)Material Data Set(MDS) assessment completed on an identified date, indicated that the resident was usually continent. Their RAI MDS assessment indicated that they were frequently

incontinent, and required the use of incontinence products. Review of progress notes indicated that they sustained injury following a number of falls resulting in decreased ambulation.

A review of the clinical records revealed that their continence had not been assessed for identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when their continence declined. This was confirmed by the ADRC responsible for Resident Assessment Inventory (RAI) .

C) A review of resident #043's RAI MDS assessment completed on admission, indicated that the resident was continent and did not use incontinence products. Their RAI MDS assessment completed on an identified date; indicated that, they were frequently incontinent and used incontinence products.

During interview, Personal Support Worker (PSW) #111 and Registered staff #112 stated that, on admission, the resident was continent, did not use incontinence products, and could ask for assistance to use the washroom. They also confirmed that shortly after admission, the resident began using incontinence products and became frequently incontinent. PSW #111 stated that the resident has been able to ask to use the washroom, was not on a toileting schedule, and could become incontinent if they had to wait for assistance with toileting, while staff were busy with other residents.

A review of the clinical records revealed, that resident #043's continence had not been assessed for identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident's continence deteriorated between identified dates. This was confirmed by the ADRC responsible for Resident Assessment Inventory (RAI) . [s. 51. (2) (a)]

2. The licensee failed to ensure that continence care products were not used as an alternative to providing assistance to toilet.

A review of resident #030's health records indicated, that they were frequently incontinent and required extensive assistance from one person for transferring. The resident had been assessed as a high risk for falls on an identified date, after having falls. Prior to these falls, the resident was usually continent. This was confirmed by

PSW #101. The resident's cognitive performance scale (CPS) was zero at the time of this inspection.

During interview on an identified date, resident #030 told the Long Term Care (LTC) Inspector that approximately 10 days earlier, they activated the call bell and requested the assistance of a specified Personal Support Worker (PSW) to go to the washroom. The resident then stated, that the PSW told them that the they didn’t need to go to the washroom because they could void in their brief. According to the resident, the PSW wouldn’t take them to the washroom, and was then incontinent in their brief.

The resident told the Long Term Care (LTC) Inspector, that they were not happy and felt very bad about being asked to do this. They voided into their brief since the PSW would not assist them to the washroom and they didn’t want to fall while trying to get to the toilet on their own.

When interviewed, Personal Support Worker (PSW) #108 denied asking the resident to void in their brief. In addition, PSW #101 would ask the resident to void in their brief if they were busy, and didn’t have time to toilet them.

Following the staff interviews, the LTC Inspector met with the DORC who was to initiate an investigation into resident #030's concern. During interview, the Assistant Director of Resident Care (ADRC) and the DRC confirmed that the home’s expectation is that staff not request that residents void in their incontinence products instead of toileting them according to their assessed and expressed needs. [s. 51. (2) (e)]

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 and ensuring ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. As well as to ensure that continence care products were not used as an alternative to providing assistance to toilet, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the Substitute Decision Maker for resident #046 had access to the written plan of care.

On an identified date and time, an incident happened involving resident #046. The resident; had a fall resulting in injury. On an identified date and time, during an interview with the Substitute Decision Maker (SDM) for resident #046; they stated, that they had requested a copy of the homes incident report on several occasions and were not provided it. The Director of Resident Care (DORC) was unable to confirm with anyone at the home that the incident report had been provided to the SDM. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating behaviours, where possible.

A review of progress notes and interview with Registered staff #105 and Personal Support Worker (PSW) #100 indicated, that resident #037 had urinated in an identified place on identified dates. The Long Term Care (LTC) Inspector observations between identified dates, indicated that identified areas had a lingering offensive urine odour.

The Assistant Director of Resident Care (ADRC) responsible for Resident Assessment Inventory (RAI) verified that the resident was functionally continent of bladder; the behaviour was responsive, and staff had reminded the resident about urinating appropriately.

A review of the document the home referred to as resident #037's care plan did not include strategies or interventions for resident #037's inappropriate urinating. This was confirmed by the ADRC. [s. 53. (4) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

A) On an identified date, resident #019 was observed in an identified dining room during the lunch meal sitting at the table with the meal served in front of them, with no assistance with eating. The resident had to wait an identified amount of time before assistance from a staff member was provided to them. The plan of care for the resident indicated they were at high nutritional risk, required total assistance with eating. Resident #019 was served a meal prior to having someone available to assist them with eating.

B) On an identified date, resident #047 was observed in an identified dining room during the lunch meal sitting at the table. The resident was observed with the meal served in front of them with no assistance with eating. The resident had to wait an identified amount of time before assistance from a staff member was provided to them, at which time they ate their whole meal. The resident's documented plan of care identified them at a moderate nutritional risk, and the most recent Minimum Data Set (MDS) Assessment, completed on an identified date, indicated the resident required extensive assistance with eating. Resident #047 was served a meal prior to having someone available to assist them with eating. [s. 73. (2) (b)]

Issued on this 1 day of February 2016 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CATHIE ROBITAILLE (536) - (A2)

Inspection No. / No de l'inspection : 2015_275536_0019 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-003433-15 (A2)

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

Report Date(s) / Date(s) du Rapport : Feb 01, 2016;(A2)

Licensee / Titulaire de permis : YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE, SCARBOROUGH, ON, M1V-5L3

LTC Home / Foyer de SLD : YEE HONG CENTRE - MISSISSAUGA
5510 Mavis Road, MISSISSAUGA, ON, L5V-2X5

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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

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Name of Administrator / Nom de l'administratrice ou de l'administrateur : MAUREEN LYNN

To YEE HONG CENTRE FOR GERIATRIC CARE, 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 :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

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

(A1)
The Licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring techniques when assisting residents. The plan is to include but is not limited to:

• All staff use safe transferring and positioning devices or techniques when assisting residents ensuring emphasis is placed on moving all objects out of immediate transfer space prior to beginning a resident transfer and positioning. As well as ensuring that all attention and focus of all staff involved in the transfer is on the resident at all times during a resident transfer and positioning.

• Update education material to include a reference to proper position of staff during two staff transfers and conduct all future education using updated education material.

• Research, review and consider incorporating best practices in safe transfer techniques in current education material and "Safe Resident Lifting & Transferring Practices" policy and procedure. I have included a link to a document developed by British Columbia Interior Health that I suggest you review and consider as an addition to your education content on safe transferring and positioning techniques. See section 5, page 4 where they illustrate safe transfer techniques using two staff, one standing directly in front of the resident's wheelchair and the other standing behind the resident's wheelchair. http: www.washingtonsafepatienthandling.org images fullguideformsipapracticalguidetoresidenthandling.pdf

The plan is to be submitted on or before Friday January 29, 2016 by email to Cathie Robitaille at Cathie.Robitaille@ontario.ca .

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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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

Grounds / Motifs :

(A2)
1. 1. The Licensee failed to ensure that staff use safe transferring and positioning devices and techniques when assisting residents.

2. On an identified date and time; resident #046 fell, resulting in injuries. The investigation notes; as well as the Director of Resident Care (DORC) and PSW #110, identified that PSW #113 at the time of the fall had their back turned away from the resident. As a result of the fall, the resident suffered significant injuries. The home failed to ensure that staff use safe transferring and positioning techniques when assisting resident #046.

3. The scope of this incident is isolated to one resident. The severity of this incident is that there was actual harm to resident #046. There is previous history of non-compliance with same regulation found in inspection #2014_266527_0024 in November 2014. (536)

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

Feb 29, 2016

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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 1 day of February 2016 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHIE ROBITAILLE - (A2)

Service Area Office /
Bureau régional de services : Hamilton