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

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

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

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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
Jun 5, 2014	2014_205129_0010	H-000810-13/H-000783-13	Complaint

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

GRACE MANOR
45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2

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

PHYLLIS HILTZ-BONTJE (129), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 14, 15 and 20, 2014

A Critical Incident Inspection #2014_337581_004/H-000367-14 was conducted concurrently and non-compliance identified during that inspection related to not reassessing the resident when their care needs change[s.6(10)(b)] and staff not complying with the home's policy [8(1)(b)] have been issued on this Complaint Inspection Report.

During the course of the inspection, the inspector(s) spoke with the resident, registered and unregulated nursing staff, the Behavioural Support Lead,the Resident Assessment Instrument-Minimum Data Set(RAI-MDS)Coordinator, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed the home's policies related to the Responsive Behaviour Management Program and reviewed the home's training records related to the Responsive Behaviour Management Program.

The following Inspection Protocols were used during this inspection: Responsive Behaviours

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:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents were reassessed and the plan of care

reviewed and revised when the resident's care needs changed, in relation to the following: [6(10)(b)]

a) Resident #003's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) review completed on August 7, 2013 indicated that the resident demonstrated two, not previously identified, indicators of altered mood. Staff also indicated the resident demonstrated a responsive behaviour, not previously identified. The Resident Assessment Protocol (RAP) completed following this review did not identify the specific observations staff made when documenting altered mood or new responsive behaviours and the document that the home used to provide care directions to staff was not revised to include care to be provided related to the resident's altered mood or the management of the identified responsive behaviour.
-The RAI-MDS review completed on October 16, 2013 indicated the resident demonstrated three, not previously identified, indicators of altered mood. The RAP completed following this review did not specify the specific indicators of altered mood being demonstrated by the resident and the document used by the home to provide care directions for staff was not revised to include care directions for staff in the management of the resident's altered mood.
-The RAI-MDS review completed on January 8, 2014 indicated the resident demonstrated an indicator of altered mood, not previously identified. The RAP completed following this review did not specify the indicator of altered mood identified and the document used by the home to provide care directions to staff was not revised to include care directions for staff in the management of this altered mood indicator.
-The RAI-MDS review completed on April 2, 2014 indicated the resident demonstrated a responsive behaviour, not previously identified. The RAP completed following this review did not identify the specific behaviour being demonstrated by the resident and the document the home used to provide care directions to staff was not revised to include care directions for the management of this responsive behaviour.(129)

b) Resident #005's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The RAI-MDS review completed on September 9, 2014 indicated the resident demonstrated two indicators of altered mood, not previously identified. The RAP completed following this review did not identify the specific indicator of altered mood observed by staff and the document the home used to provide care directions to staff was not revised following this review to provide care directions for staff in the

management of the resident's altered mood.
-The RAI-MDS review completed on December 17, 2013 indicated the resident demonstrated four, not previously identified, indicators of altered mood. The RAP completed following this review did not identify the specific indicators of altered mood observed by staff and the document used in the home to provide care directions to staff was not revised following this review to provide care directions for staff in the management of the resident's altered mood. (129)

c) Resident #007's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The RAI-MDS review completed on March 25, 2014 indicated the resident demonstrated a not previously identified, responsive behaviour. The RAP completed following this review did not identify the specific behaviour or in which situations this behaviour was being demonstrated. The clinical record indicated the document used by the home to provide care directions to staff was not revised following this review to provide care directions for staff in the management of this responsive behaviour. (129)

d) Resident #002's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed in relation to the following, [6 10(b)]
-Resident #002 fell while walking three times in a fourteen day period and the resident's care plan was not reviewed and revised to include direction to prevent falling and minimize injuries from falling when the resident was walking. Interventions were not implemented to manage the falls after the above noted three falls. The resident fell a month after the last fall identified above and was transferred to hospital. Registered staff documented in the clinical record that the family reported the resident had sustained an injury a result of the last fall.
-On an identified date the resident's care needs changed when they were placed in a tilt wheelchair and restrained. Registered staff and the Personal Support Workers (PSW) confirmed that Resident #002 was a two person transfer at all times and was no longer walking or transferring independently as they were confined to a tilt wheelchair.
The care plan in place at the time of this inspection identified that Resident #002 would retain their ability to stand over the next ninety days and may be independent some days or may require one to two staff physical assistance. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's ambulatory status changed. (581)
(PLEASE NOTE:This non-compliance was identified during a Critical Incident

Inspection #2014_337581_004/H-000367-14 that was conducted concurrently has been issued on Complaint Inspection # 2014_205129_0010/H-000810-13/H-000783-13. [s. 6. (10) (b)]

2. The licensee did not ensure residents were reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective, in relation to the following: [6(10)(c)]
a) Resident #003's plan of care was not reviewed or revised when it was documented in the clinical record that the care set out in the plan was not effective
-The goals of care identified during the RAI-MDS review completed on May 8, 2013 was that both mood state and responsive behaviours would improve. Staff documented on the following RIA-MDS review completed on August 7, 2013 that there had been no change in three identified indicators of altered mood. Staff also documented that there had been no change in the responsive behaviours being demonstrated by the resident. Staff also documented and that one identified responsive behaviour had deteriorated since the last review. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in improving the resident's mood state or reducing episodes of responsive behaviours being demonstrated.
-The goals of care identified during the RAI-MDS review completed on August 7, 2013 was that the resident's mood state would improve and complications would be avoided as well as the responsive behaviours being demonstrated by the resident would improve. Staff documented on the following RAI-MDS review completed on October 16, 2013 that there had been no change in three of the identified indicators of altered mood. Staff also documented that there had been no change in the responsive behaviours being demonstrated by the resident. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in improving the resident's mood state or reducing the episodes of identified responsive behaviours.
-The goals of care identified during the RAI-MDS review completed on January 8, 2014 was that the resident's mood state would improve/slow or minimize decline/avoid complications, the responsive behaviours being demonstrated by the resident would improve and complications would be avoided. Staff documented on the following RAI-MDS review completed on April 2, 2014 that there had been no change in two of the identified indicators of altered mood. Staff also documented that three of the identified indicators of altered mood had deteriorated since the last review. The documentation

on this review also indicated that there had been no change in responsive behaviours being demonstrated by the resident. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in reaching the goals of care established.

b)Resident #005's plan of care was not reviewed or revised when it was documented in the clinical record that the care set out in the plan had not been effective.
-The goal of care identified during the RAI-MDS review completed on July 2, 2013 was that the resident's mood state would improve. Staff documentation on the following RAI-MDS review completed on September 24, 2013 that there had been no change in three of the previously identified mood indicators. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in reaching the goal of care established.
-The goals of care identified during the RAI-MDS review completed on September 24, 2013 was that the resident's mood state would improve and decline would be slowed or minimized. Staff documented on the following RAI-MDS completed on March 18, 2014 that there had been no change in four of the previously identified mood indicators. The documentation on this review also indicated that one previously identified mood indicator was being demonstrated more frequently than during the previous review period. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in reaching the goals of care established.

c) Resident #007's plan of care was not reviewed or revised when it was documented in the clinical record that the care set out in the plan had not been effective.
-The goal of care identified during the RAI-MDS review completed on October 10, 2013 was that the resident's mood state would improve. Staff documentation on the following RAI-MDS completed on December 3, 2013 indicated that one of the mood indicators previously identified had deteriorated since the previous review and the resident demonstrated this altered mood indicator more frequently. The clinical record confirmed that the document used by the home to provide care directions to staff had not been reviewed or revised when staff identified that the care being provided to the resident had not been effective in reaching the goal of care established. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee to have or put in pace any policy, procedure or strategy, that the policy, procedure or strategy was complied with, in relation to the following: [8(1)(b)]
a) Staff did not comply with the directions contained in the home's Responsive Behaviour policy and procedure identified as #30-36-14A and reviewed on January 11, 2013.

1. The policy directed that each resident with responsive behaviours will have individual resident behavioural triggers identified. Staff did not comply with this direction, in relation to the following:
- On April 2, 2014 staff documented resident #003 was demonstrating five responsive behaviours; however, triggers for these behaviours were not identified.
-On March 25, 2014 staff documented resident #007 was demonstrating one responsive behaviour; however, triggers for this behaviour were not identified.

2. The policy directed that annually the program for Responsive behaviours would be evaluated and updated. The Director of Care confirmed that the program for Responsive Behaviours was not evaluated or updated in 2013.

b) Staff did not comply with the directions contained in the home's [Resident Fall With No Injury or Minor Injury] identified as #30.06.11 reviewed on June 18, 2012.
Staff did not comply with the directions included in the policy to ask the resident if they hurt themselves, check for bleeding or possible head injury, if head injury was possible staff were begin head injury routine and complete a head to toe assessment for possible injury or fracture prior to assisting the resident to a more comfortable position. On an identified date, documentation in the clinical record indicated that Resident #002 fell while receiving care. The resident had an obvious head injury when staff documented in the progress notes that the resident had blood on the front of their hair and head. Two PSW staff transferred the resident from the floor to a standing position and walked the resident down the hall prior to being assessed for injury by the registered staff. As a result of this injury the resident was transferred to hospital for further assessment. (581)
(PLEASE NOTE:This non-compliance was identified during a Critical Incident Inspection #2014_337581_004/H-000367-14 that was conducted concurrently and has been issued on Complaint Inspection # 2014_205129_0010/H-000810-13/H-000783-13. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that staff comply with the homes policies, procedures and protocols, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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 did not ensure that the written strategies and protocols in place to meet the needs of residents with responsive behaviours were evaluated at least annually, in relation to the following: [53(3)(b)]
The Director of Care confirmed that an annual review of the strategies and protocols in place to meet the needs of residents demonstrating responsive behaviours were not evaluated in 2013. [s. 53. (3) (b)]

2. The licensee did not ensure that for each resident demonstrating responsive behaviours, that behavioural triggers for the resident were identified, where possible, in relation to the following: [53(4)(a)
a) During a RAI-MDS review of resident #003's care needs completed on April 2, 2014 staff documented resident #003 demonstrated five responsive behaviours. At the time of this inspection there was no evidence in the clinical record that staff attempted to identify behavioural triggers for these behaviours.
b) During a RAI-MDS review of resident #007's care needs completed on March 25, 2014 staff documented resident #007 demonstrated one responsive behaviour. At the time of this inspection there was no evidence in the clinical record that staff attempted to identify behavioural triggers for this behaviour. [s. 53. (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 for each resident demonstrating responsive behaviours that behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

Issued on this 2nd day of July, 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) :	PHYLLIS HILTZ-BONTJE (129), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2014_205129_0010
Log No. / Registre no:	H-000810-13/H-000783-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 5, 2014
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

To HOLLAND CHRISTIAN HOMES INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure residents who demonstrate responsive behaviours and experience falls, including resident #003, resident #005, resident #007 and resident #002 are reassessed and the plan of care reviewed and revised whenever the resident's care needs change.
The plan is to include, but is not limited to the following:
1. The development and implementation of a protocol staff must follow when it is identified that the care needs of a resident have changed.
2. The development and implementation of a training program for staff to ensure staff identify when the care needs of the residents have changed as well as training on the use of the above noted protocol.
3. The implementation of a schedule of monitoring staff's performance in the implementation of the above noted protocol.
The plan is to be submitted on or before June 13, 2014 , by mail, to Phyllis Hiltz-Bontje at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at, Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non compliant on October 8, 2012 as a VPC.
2. Three of four residents reviewed were not reassessed and the plan of care reviewed and revised when the resident's care needs changed.
3. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation

to the following: [6(10)(b)]
a) Resident #003's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) review completed on August 7, 2013 indicated that the resident demonstrated two, not previously identified, indicators of altered mood. Staff also indicated the resident demonstrated a responsive behaviour, not previously identified. The Resident Assessment Protocol (RAP) completed following this review did not identify the specific observations staff made when documenting altered mood or responsive behaviour and the document that the home used to provide care directions to staff was not revised to include care to be provided related to the resident's altered mood or the management of the identified responsive behaviour.
-The RAI-MDS review completed on October 16, 2013 indicated the resident demonstrated three, not previously identified, indicators of altered mood. The RAP completed following this review did not specify the specific indicators of altered mood being demonstrated by the resident and the document used by the home to provide care directions for staff was not revised to include care directions for staff in the management of the resident's altered mood.
-The RAI-MDS review completed on January 8, 2014 indicated the resident demonstrated an indicator of altered mood, not previously identified. The RAP completed following this review did not specify the specific indicator of altered mood being demonstrated by the resident and the document used by the home to provide care directions to staff was not revised to include care directions for staff in the management of this altered mood indicator.
-The RAI-MDS review completed on April 2, 2014 indicated the resident demonstrated a responsive behaviour, not previously identified. The RAP completed following this review did not identify the specific behaviour being demonstrated by the resident and the document the home used to provide care directions to staff was not revised to include care directions for the management of this responsive behaviour.(129)

b) Resident #005's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The RAI-MDS review completed on September 9, 2014 indicated the resident demonstrated two indicators of altered mood, not previously identified. The RAP completed following this review did not identify the specific indicators of altered mood being demonstrated by the resident and the document the home used to provide care directions to staff was not revised following this review to provide care directions for staff in the management of the resident's altered mood.

-The RAI-MDS review completed on December 17, 2013 indicated the resident demonstrated four, not previously identified, indicators of altered mood. The RAP completed following this review did not identify the specific observations staff made that lead them to document these changes and the document used in the home to provide care directions to staff was not revised following this review to provide care directions for staff in the management of the resident's altered mood. (129)

c) Resident #007's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
-The RAI-MDS review completed on March 25, 2014 indicated the resident demonstrated a not previously identified responsive behaviour. The RAP completed following this review did not identify the specific behaviour or in which situations this behaviour was being demonstrated. The clinical record indicated the document used by the home to provide care directions to staff was not revised following this review to provide care directions for staff in the management of this responsive behaviour. (129)

d) Resident #002's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed.
- Resident #002 fell while walking three times in a fourteen day period and the resident's care plan was not reviewed and revised to include directions to prevent falling and minimize injuries from falling when the resident was walking. Interventions were not implemented to manage the falls of resident #002 after these identified falls. The resident fell a month after the last identified fall and was transferred to hospital. Registered staff documented in the clinical record that the family reported the resident had sustained an injury as a result of the fall.
-On an identified date the resident's care needs changed when they were placed in a tilt wheelchair and a restraint. Registered staff and the Personal Support Workers (PSW) confirmed that Resident #002 was a two person transfer at all times and was no longer walking or transferring independently as they were confined to a wheelchair. The care plan in place at the time of this inspection identified that Resident #002 would retain their ability to stand over the next ninety days and may be independent some days or may require one to two staff physical assistance. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's ambulatory status changed. (581)
(PLEASE NOTE: this evidence of non-compliance was found during Inspection # 2014_205129_0010/H-000810-13/H-000783-13)

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 10, 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
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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 5th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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