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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2016	2016_248214_0003	002497-16	Resident Quality Inspection

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street St. Catharines ON L2N 4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street St. Catharines ON L2N 4J4

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

CATHY FEDIASH (214), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 28, 29, February 2, 3, 4, 5, 8, 9, 10, 11, 2016.

Please note: The following inspections were conducted simultaneously with this RQI:
-Follow up inspection 029934-15 related to s.20(1)-Policy to promote zero tolerance.
-Follow up inspection 029935-15 related to r.71(3)-Menu planning.
-Follow up inspection 029936-15 related to r.71(4)-Menu planning.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Dietary Manager, Environmental Services Manager, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian, registered staff, Personal Support Workers (PSW), President of Residents' Council, residents and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

15 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2015_30610a_0013	214
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2015_205129_0002	214
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2015_205129_0002	214
O.Reg 79/10 s. 71. (4)	CO #003	2015_30610a_0013	583

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed, in accordance with prevailing practices, in relation to the following: [15(1)(a)]

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents were to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail was a safe device for resident use. The guideline emphasized the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) An evidenced based assessment for resident #001 was not completed prior to a specified safety device being used as a care intervention. The resident was observed at

1416 hours, on an identified date in 2016, to be in the bed with the specified safety device in the active position. Registered staff #091 and clinical documentation confirmed that the plan of care directed staff to use the specified safety device whenever this resident was in bed. Registered staff #086 and clinical documentation confirmed that there was not an evidenced based assessment completed related to the use of this specified safety device.

B) An evidenced based assessment for resident #010 was not completed prior to a specified safety device being used as a care intervention. The resident was observed at 1434 hours, on an identified date in 2016, to be in bed with the specified safety device in the active position. Registered staff #091 and clinical documentation confirmed that the plan of care directed staff to use the specified safety device whenever this resident was in bed. Registered staff #086 and clinical documentation confirmed that there was not an evidenced based assessment completed related to the use of this specified safety device.

C) Registered staff #128 confirmed that the home has not developed or implemented an assessment for the resident when a specified safety device was being considered that complied with the prevailing practice document identified above. A tour of the home was completed at 1434 hours, on an identified date in 2016 and at that time 27 residents were noted to be in bed with a specified safety device in the active position. A task report generated, confirmed that 57 of 106 residents in the home had plans of care that directed staff to use the specified safety device whenever the resident was in bed related to a risk of falling. None of the above identified residents were assessed according to prevailing practice before initiating the use of the specified safety device as a care intervention. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a snack in the afternoon.

A) During an observation of the afternoon snack service on an identified date in 2016, staff #006 was observed handing out beverages to resident's. The snack cart was observed to contain no snack items. In an interview with staff #006, when snack service was complete, it was confirmed that a food item was not offered to resident's on regular or modified diet textures. In an interview with staff member #099 and #006 at the end of snack service it was shared that they were not clear as to what was required to be offered to residents during afternoon snack service.

B) During an interview with staff #013 and #017 on an identified date in 2016, it was confirmed that a pureed snack item was not offered to five residents. During an observation of the kitchen fridge with staff #107, three planned menu puree snack items were present. Staff #107 shared that additional prepared puree items were available in the main kitchen. In an interview with staff #013 and #017 it was shared they were not clear as to what snack was required to be offered to residents on a puree diet during afternoon snack service. [s. 71. (3) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During an interview on an identified date in 2016 with resident #303 and their family member it was shared what the resident's code status was on the "transfer/discharge report" they received on two identified dates in January 2016 and one identified date in February 2016. A review of the plan of care identified that resident #303 had changed their advanced health care directive to an identified level. In an interview with staff #128, it was confirmed that the plan of care did not provide clear direction as the code status in the physician's orders was identified as a certain code and the hard copy in the chart was identified as a different code. It was confirmed with resident #303 and their family member they wished be have the code status that was identified in the hard copy in the resident's chart . [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was reviewed and revised at any time when the resident's care needs changed or when the care set out in the plan was no longer necessary.

A) In an interview with resident #002 on an identified date in 2016 and staff #006 and #024, it was identified the resident was incontinent and required extensive assistance

with toileting and continence care. A review of the toileting and continence care plan identified resident #002 required limited assistance for toileting and directed staff to use verbal reminders for continence control and check for wetness on night shift. In an interview with staff #128 on an identified date in 2016, it was confirmed resident #002 could no longer toilet independently and required checks for wetness during the day shift in addition to the night shift. It was confirmed that resident #002's toileting and continence care plan was not reviewed and revised when the residents care needs changed. (#583)

B) A review of resident #007's Minimum Data Set (MDS) quarterly assessment dated on an identified date in 2015, indicated under section I.- Disease Diagnoses that the resident was coded as having a respiratory infection. A review of the resident's clinical record indicated that the resident began demonstrating signs and symptoms of a respiratory infection five days prior to their MDS assessment and orders were received by the physician for treatment and diagnostics. A progress note completed by the physician six days following the start of their symptoms indicated that the resident felt better and their chest was clear. A review of the resident's written plan of care in place for the above time period indicated that no plan was in place to identify the resident's respiratory infection including interventions to manage their infection.

An interview with staff #128 confirmed that the resident's plan of care was not reviewed and revised when they developed a respiratory infection and their care needs changed. (214) [s. 6. (10) (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 to ensure that the written plan of care for each resident set's out clear direction to staff and others who provide direct care to the resident and that the plan of care is reviewed and revised at any time when the resident's care needs changed or when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 failed to ensure that where the Act or this regulation required the licensee to have, institute or otherwise put in place any plan, policy or procedure, that the plan, policy or procedure was in compliance with all applicable requirements under the Act, in relation to the following: [8(1)(a)]

1. Registered staff #128 confirmed that the home's "Skin and Wound Care Program" with a revised date of May 2015, did not comply with the requirement identified in O. Reg. 79/10, s. 50(2)(b). The requirements identified that "residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds is reassessed weekly by a member of the registered nursing staff, if clinically indicated and is assessed by a registered dietitian who is a member of the staff of the home".

A) The home's Skin and Wound Care Program did not comply with the requirement for weekly skin reassessments, when it did not direct staff to complete weekly reassessments for residents who exhibited altered skin integrity including skin breakdown, skin tears and wounds and only directed staff to complete weekly reassessments for residents who exhibited pressure ulcers.

B) The home's Skin and Wound Care Program did not comply with the requirement that a resident who exhibited altered skin integrity as identified above was to be assessed by a registered dietitian. The program did not provide clear direction to staff that the registered dietitian was to be made aware of any resident's who exhibited altered skin integrity, but instead directed staff to make referrals to interdisciplinary team members, as required, when a resident was identified as being at risk for altered skin integrity. Registered staff #136 confirmed that a referral to the registered dietitian was not completed when staff identified on an identified date in 2015, that resident #010 exhibited

an identified alteration to their skin or on another identified date approximately five months later, when resident #010 exhibited a different identified alteration to their skin.

2. Registered staff #134 and #135 confirmed that the home's "Responsive Behaviour Policy", identified as N-13.36 and reviewed in May 2015, did not comply with the requirements identified in O. Reg. 79/10, s. 53(4). The requirements indicated that for each resident who demonstrated responsive behaviours, the behavioural triggers for the resident were identified, were possible. The home's policy did not direct staff to identify possible triggers for behaviours resident's demonstrate and the policy did not contain an assessment tool or protocol for assessing behaviours in order to identify possible behavioural triggers. [s. 8. (1) (a)]

2. The licensee failed to ensure that where the Act or this regulation requires the licensee to have, institute or otherwise put in place any plan, policy or procedure, that the plan, policy or procedure was complied with, in relation to the following: [8(1)(b)]

1. Staff did not comply with the directions in the home's "Skin and Wound Care Program" with a revised date of May 2015.

A) The program directed that for residents with pressure ulcers, staff were to ensure that the plan of care was established outlining interventions and treatments. Registered staff #134 and clinical documentation confirmed that this direction was not complied with when resident #010 was identified as having an alteration to their skin to an identified area on their body in 2015. A plan of care was not developed outlining interventions for staff providing direct care to the resident related to their alteration in skin.

B) The program directed that after a dressing change, staff were to complete the Pressure Ulcer/Wound Assessment Record weekly. Registered staff #134 and clinical documentation confirmed that this direction was not complied with when resident #010 was identified as having an alteration to their skin. The resident was identified to exhibit this alteration in skin integrity on an identified date in 2015 and during the course of their alteration in skin integrity there were three identified periods of time where this wound was not reassessed for periods of 20,18 and 18 days.

2. Staff did not comply with directions contained in the home's "Bed Rail Policy", identified as #N-13.20. This policy directed that "residents using side rails are considered a personal assistive safety device and must be monitored by staff on an hourly basis and staff must initial every hour that they have monitored the resident for safety". Registered

staff #134 and clinical documentation confirmed that staff did not comply with this direction when it was identified that resident #001 and resident #010 were observed to be in bed with an identified safety device in the active position on an identified date in 2015 and the clinical record did not contain documentation that the residents had been checked hourly for safety when the identified safety devices were engaged. Both resident #001's and resident #010's plans of care directed staff that the safety devices were to be engaged when in bed for safety.

3. Staff did not comply with directions contained in the home's "Bed Entrapment Prevention Program". This program directed that "decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal guardian". This program outlined factors that should be considered when completing the individualized resident assessment. Registered staff #128 and clinical documentation confirmed that this program was not complied with when 57 of 106 resident's who were identified as using bed rails did not receive an individualized resident assessment before the use of bed rails as a care intervention.

4. Staff did not comply with the directions in the home's "Responsive Behaviour Policy", identified as # N-13.36 with a revised date of May 2015. This policy directed that staff were to adapt strategies for the individual that respond to triggers and responsive behaviour. Registered staff #134 and #135 confirmed that when staff documented an increase in identified behaviours for resident #011 on a specified date in 2015 and when staff documented an increase in identified behaviours for resident #004 on a specified date in 2015, strategies were not developed to respond to these responsive behaviours. [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 to ensure that where the Act or this regulation requires the licensee to have, institute or otherwise put in place any plan, policy or procedure, that the plan, policy or procedure is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) An interview with the DOC confirmed that the home had not completed an annual program evaluation for their Continence Care and Bowel program in 2015. (#214)

B) The DOC indicated the home did not have a format for reviewing organized and interdisciplinary programs and confirmed the Skin and Wound Program, the Training and Orientation program and the Responsive Behaviour Program had not been reviewed annually. (#129) [s. 30. (1) 3.]

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 following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, in relation to the following: [50(2)(b)(iv)]

A skin and wound assessment completed on an identified date in 2015, indicated that resident #010 had an identified area of altered skin integrity on their body and had recorded specific measurements of the residents altered skin integrity. Registered staff #134 and clinical documentation confirmed that the following reassessment completed five days later, indicated the wound had not changed from the previous assessment. The following reassessment completed 20 days later indicated the size of the wound had increased slightly and identified measurements were recorded. Registered staff #134 and clinical documentation confirmed that wound reassessments for this identified alteration in skin integrity were completed on two identified dates in August 2015, one identified date in September 2015, 18 days later on another identified date in September 2015, 18 days later on an identified date in October 2015 and seven days following this last assessment on an identified date in October 2015. There were no further skin alteration reassessments completed; however; a skin assessment completed nine days later confirmed that the resident continued to have this identified alteration to their skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 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 for each resident who demonstrated responsive behaviour, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to the behaviours and actions were taken to respond to the needs of the resident, including reassessment, in relation to the following: [53(4)(a)(b)&(c)]

A) Staff did not attempt to identify behavioural triggers, develop strategies to respond to the resistant behaviour or reassess resident #011 when it was identified that the resident demonstrated an increase in their identified responsive behaviours. MDS data collected on an identified date in 2015, indicated the resident did not demonstrate the identified

behaviours, data collected during the following MDS review completed on an identified date in 2015, indicated the resident demonstrated the identified responsive behaviour one to three days in the last seven days and that this behaviour was easily altered. The Resident Assessment Protocol (RAP) completed following the MDS review indicated the resident's identified responsive behaviour. The following MDS review completed on an identified date in 2016, continued to identify that the resident remained with the identified responsive behaviour one to three days in the last seven days and the associated RAP had not changed from the one completed on an identified date in 2015. Registered staff #134, #135 and clinical documentation confirmed that there was not an attempt made to identify possible triggers for this behaviour, the home had not developed an assessment protocol to assist staff in the identification of possible triggers for behaviours, strategies had not been developed to respond to this behaviour, the care plan related to this identified behaviour had not been altered since an identified date in 2014 and the resident had not been reassessed when this behaviour was identified.

B) Staff did not attempt to identify behavioural triggers, develop strategies to respond to the resistant behaviours or reassess resident #004 when it was identified that the resident demonstrated an increase in a specified responsive behaviour. Data collected during a MDS review completed on an identified date in 2015, indicated that the specified behaviours occurred one to three days in the last seven days and the behaviour was not easily altered. The associated RAP completed at this time indicated the resident's specified responsive behaviour was to care routines. Data collected on the following MDS review completed on an identified date in 2015, indicated the same resistive behaviours had increased, were now being demonstrated daily and were not easily altered. Registered staff #134, #135 and clinical documentation confirmed that the specified behaviours documented as being demonstrated were not clearly identified, there was not an attempt made to identify possible triggers for these behaviours, the home had not developed an assessment protocol to assist staff in the identification of possible triggers for behaviours, there were no strategies identified in the resident's plan of care to respond to these behaviours, and the resident had not been reassessed when these behaviours had increased. [s. 53. (4)]

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 for each resident demonstrating responsive behaviour, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to the behaviours and actions are taken to respond to the needs of the resident, including reassessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that if there was no Family Council, semi-annual meetings were convened to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Registered staff #128 confirmed that the home did not have a Family Council at the time of this inspection and although a notice was placed in the May 2015 Heidehof News asking if there was any interest in starting a Family Council, the home did not convene semi-annual meetings in 2015 to advise residents' families and persons of importance to residents of the right to establish a Family Council. [s. 59. (7) (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 to ensure that if there is no Family Council, semi-annual meetings are convened to advise residents' families and persons of importance to residents of the right to establish a Family Council, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the weight monitoring system to measure and record with respect to each resident included a measured monthly weight for all residents.

Monthly weight documentation in Point Click Care (PCC) and paper documentation completed on the "monthly resident weights, blood pressure and pulse record" was reviewed for resident #300, #301 and #302. Over a six month period resident #300 had no measured weight completed for identified dates in 2015 and 2016, resident #301 had no measured weight completed for three identified time periods in 2015 and resident #302 had no measured weight completed for an identified time in 2015. In an interview with staff #136 on an identified date in 2016, it was confirmed the weights were not completed and no documentation was available to explain why measurements could not be obtained. [s. 68. (2) (e) (i)]

2. The licensee failed to ensure that the nutrition care and hydration programs included, (ii) body mass index and height upon admission and annually thereafter.

During stage one of the Resident Quality Inspection (RQI), census record reviews conducted indicated that not all resident's had their height obtained on an annual basis. A review of resident #009's clinical record indicated that their last documented height was on an identified date in September 2011. Resident #400's last documented height was on an identified date in November 2011 and resident #401's last documented height was on identified date in December 2011.

An interview with staff #128 and #136 confirmed that the resident's identified above had not had their height measured and documented on an annual basis. [s. 68. (2) (e) (ii)]

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 weight monitoring system to measure and record with respect to each resident includes a measured monthly weight for all residents and height upon admission and annually thereafter, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with O. Reg. 79/10, s. 219(1) in the area of behaviour management.

Registered staff #134 confirmed that training in the area of behaviour management was not provided to staff who provided direct care to residents in 2015. [s. 76. (7) 3.]

2. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219(1) in the area of continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)3, in relation to the following: [76(7)6]

An interview with registered staff #128 confirmed that the home had only provided annual retraining in the area of continence care and bowel management to 80 percent of staff who provided direct care in 2015. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in accordance with O. Reg. 79/10, s. 219(1) in the area's of behaviour management and continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)3, in relation to the following: [76(7)6], to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment in the home in accordance with manufacturers' instructions.

During a tour of the tub room on the first floor on an identified date in 2016, staff #006 and #024 shared that the hygiene lift chair safety belt was only used for some resident's when lifting them in and out of the tub. A review of the manufacturer instructions stated "the safety belt must be used at all times to make sure the resident remains in an upright position in the middle of the seat". In an interview with staff #128, it was confirmed that the safety belt was not being used for all resident's on an identified floor in the home who used the hygiene lift chair and that the equipment was not used in accordance with the manufacturers' instructions. [s. 23.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A) A review of resident #009 personal hygiene plan of care identified they required constant supervision with physical assistance for oral hygiene. During a review of the plan of care and in an interview with staff #128 on an identified date in 2016, it was verified that there was no interdisciplinary assessment of resident #009's dental and oral status including oral hygiene requirements. It was confirmed that the plan of care was not based on an interdisciplinary assessment.

B) A review of resident #002 personal hygiene plan of care identified they required extensive assistance with mouth care. In an interview with resident #002 on an identified date in 2016, they shared they required staff to provide their oral care. During a review of the plan of care and in an interview with staff #128, it was verified that there was no interdisciplinary assessment of resident #002's dental and oral status including oral hygiene requirements. It was confirmed that the plan of care was not based on an interdisciplinary assessment. [s. 26. (3) 12.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team who provided a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

A) An interview with the family representative for resident #004 indicated that they did not recall having participated in a care conference with the interdisciplinary team within six weeks of the resident's admission and annually after. A review of the resident's clinical records identified that no documentation was available to indicate that a six week care conference was held following the resident's admission on an identified date in 2012, as well as annually after. An interview with staff #128 confirmed that a care conference was not held within six weeks of the resident's admission and annually after.

B) An interview with the family representative for resident #011 indicated that they did not recall having participated in a care conference with the interdisciplinary team within six weeks of the resident's admission and annually after. A review of the resident's clinical records identified that no documentation was available to indicate that a six week care conference was held following the resident's admission on an identified date in 2013, as well as annually after. An interview with staff #128 confirmed that a care conference was not held within six weeks of the resident's admission and annually after. [s. 27. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and cleaning of dentures.

In an interview with resident #002 on an identified date in 2016, they shared that staff clean their upper teeth but do not always clean the resident's bottom teeth. In an interview with resident #002 on an identified date in 2016, they shared that their bottom teeth had not been brushed. In an interview with staff #024 who had provided care on this identified date, it was confirmed that resident #002's bottom teeth had not been brushed as part of their oral care requirments. [s. 34. (1) (a)]

WN #15: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

During the stage one resident quality inspection interview on an identified date in 2016, resident #002 shared their brief was last changed when they received help in the evening hours on the day prior. The plan of care identified that the resident required continence care and it was determined at the time of the interview that the resident required total care. In an interview with staff #006 and #024, it was confirmed that the morning shift had not provided continence care on this specified date. Staff #006 and #024 provided continence care and Long Term Care Homes (LTCH) inspector #583 observed the resident's continence care product to be heavily saturated with urine. [s. 51. (2) (g)]

Issued on this 4th day of April, 2016

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2016_248214_0003
Log No. / Registre no:	002497-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 24, 2016
Licensee / Titulaire de permis :	BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED 600 Lake Street, St. Catharines, ON, L2N-4J4
LTC Home / Foyer de SLD :	HEIDEHOF LONG TERM CARE HOME 600 Lake Street, St. Catharines, ON, L2N-4J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELENA CADDIS

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Immediately develop and implement an assessment tool for assessing residents for bed rail use and bed rail safety concerns, incorporating the guidelines identified in the document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Appropriate action related to the use of bed rails is to be taken for each resident following the above noted assessment and the assessment is to be documented in the resident's clinical record by April 29, 2016.

2. Provide bed safety education to all staff who provide care to residents, by May 27, 2016. The education at a minimum shall include information related to bed entrapment zones 1-4, when to apply bed rails, how staff will be informed as to when to apply bed rails, how to recognize when a bed is unsafe, how and when to report bed safety concerns, and how residents are to be assessed prior to the use of bed rail.

Grounds / Motifs :

1. A) Previously identified as non-compliant and issued as a WN on August 5, 2015.

2. The licensee failed to ensure that where bed rails were used, the resident was assessed, in accordance with prevailing practices, in relation to the following: [15(1)(a)] According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents were to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail was a safe device for resident use. The guideline emphasized the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) An evidenced based assessment for resident #001 was not completed prior to a specified safety device being used as a care intervention. The resident was observed at 1416 hours, on an identified date in 2016, to be in the bed with the specified safety device in the active position. Registered staff #091 and clinical documentation confirmed that the plan of care directed staff to use the specified safety device whenever this resident was in bed. Registered staff #086 and clinical documentation confirmed that there was not an evidenced based assessment completed related to the use of this specified safety device.

B) An evidenced based assessment for resident #010 was not completed prior to a specified safety device being used as a care intervention. The resident was observed at 1434 hours, on an identified date in 2016, to be in bed with a specified safety device in the active position. Registered staff #091 and clinical documentation confirmed that the plan of care directed staff to use the specified safety device whenever this resident was in bed. Registered staff #086 and

clinical documentation confirmed that there was not an evidenced based assessment completed related to the use of this specified safety device.

C) Registered staff #128 confirmed that the home has not developed or implemented an assessment for the resident when a specified safety device was being considered that complied with the prevailing practice document identified above. A tour of the home was completed at 1434 hours, on an identified date in 2016 and at that time 27 residents were noted to be in bed with a specified safety device in the active position. A task report generated on an identified date in 2016, confirmed that 57 of 106 residents in the home had plans of care that directed staff to use the specified safety device whenever the resident was in bed related to a risk of falling. None of the above identified residents were assessed according to prevailing practice before initiating the use of the specified safety device as a care intervention.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_30610a_0013, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

1. Ensure that all residents in the home are offered a snack in the afternoon and evening including residents on both regular diet textures and modified diet textures.

2. Ensure that front line nursing staff and food service staff work together and follow the multidisciplinary process that the home has developed to ensure all residents are offered snacks between meals.

3. Ensure front line nursing staff and food service staff are educated on the snack service process and the requirements of O.Reg 79/10, s. 71. (3).

4. Complete paper and visual audits to ensure residents are being offered a snack in the afternoon and evening on first, second and third floor.

Grounds / Motifs :

1. A) Previously identified as non-compliant with a CO on September 22, 2015.

B) During an observation of the afternoon snack service on an identified date in 2016, staff #006 was observed handing out beverages to residents. The snack cart was observed to contain no snack items. In an interview with staff #006 at 1435 hours, when snack service was complete it was confirmed that a food item was not offered to residents on regular or modified diet textures. In an interview with staff member #099 and #006 at the end of snack service it was shared that they were not clear as to what was required to be offered to residents during afternoon snack service.

C) During an interview with staff #013 and #017 on an identified date in 2016, at 1420 hours, it was confirmed that a pureed snack item was not offered to five residents. During an observation of the kitchen fridge with staff #107 three planned menu puree snack items were present. Staff #107 shared additional prepared puree items were available in the main kitchen. In an interview with staff #013 and #017 it was shared they were not clear as to what snack was required to be offered to residents on a puree diet during afternoon snack service. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 24th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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