Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2017;	2016_558123_0016 (A1)	034429-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

ST JOSEPH'S LIFECARE CENTRE
99 WAYNE GRETZKY PARKWAY BRANTFORD ON N3S 6T6

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

MELODY GRAY (123) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001 was rescinded

Issued on this 27 day of February 2017 (A1)

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

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

MELODY GRAY (123) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 15, 16, 19, 20, 21, 22, 28 & 29, 2016

The following inspections were completed concurrently with the RQI:

Follow-up Inspection

028744-16 related to responsive behaviour

Critical Incidents

027181-16 related to alleged abuse

034731-16 related to alleged abuse

034956-16 related to alleged abuse

003907-17 related to alleged abuse

Complaints

022158-16 related to improper care

034803-16 related to alleged abuse

034822-16 related to alleged abuse

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Spiritual Care Transitions Program Manager, Restorative Program staff, registered staff, Resident Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Director of Care (DOC), Quality Manager and Administrator.

The Inspectors also toured the home; observed infection prevention and control practices; reviewed the medication management system; reviewed the home's records including policies and procedures and reviewed residents' records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **6 WN(s)**
- **5 VPC(s)**
- **1 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
O.Reg 79/10 s. 53. (4)	CO #001	2016_511586_0006	123

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff as evidenced by:

The records of residents #040 and #041 who both resided in an identified home area and were noted to have cognitive impairments were reviewed. Resident #040 was identified as having responsive behaviors. The resident's history also included being involved in altercations with co-residents. Multiple incidents of altercations with co-residents were noted in the resident's record and in some instances resident #040 was the aggressor. The care plan identified the resident's responsive behaviors. Interventions included pharmacological and non-pharmacological interventions. External service providers were involved in the care of the resident. The Nursing Quarterly Supplemental Note dated March, 2016 indicated that resident #040 had sustained injuries related to their physical altercations but all resolved without further medical intervention. The Nursing Quarterly Supplemental Note dated June, 2016 noted that resident #040 remained prone to periodic minor physical injuries related to their physical altercations. The Nursing Quarterly Supplemental Note dated September, 2016 indicated that resident #040 remained prone to periodic minor physical injuries related to physical altercations and any affected areas are reassessed weekly for the progression of healing.

Resident #041 was noted to have a history of responsive behaviors. On an identified date in December, 2016 resident #040 was involved in a physical altercation with resident #041. The staff separated the residents. Resident #040 sustained physical injury

Critical Incident (CI) report was reviewed and contained information as above. The Director of Care (DOC) was interviewed and confirmed that resident #040 was physically abused by resident #041.

The records of residents #040 and #042 were reviewed. The review of resident #040's record revealed information as above.

The review of resident #042's record indicated resided in an identified home area and was cognitively impaired. They had a history of responsive behaviors which at times resulted in altercations with co-residents. External service providers were involved in their care. The care plan interventions included pharmacological and non-pharmacological approaches.

It was noted that on an identified date in August, 2016 resident #040 and resident #042 were involved in a physical altercation after resident #040 entered the room of resident #042. The altercation resulted in resident #040 sustaining minor physical injury. The CI report was reviewed and indicated information as above. The DOC was interviewed and confirmed that resident #040 was physically abused by resident #042.

The records of residents #040 and #048 were reviewed. The review of resident #040's record revealed information as above.
Resident #048 resided in an identified home area and was cognitively impaired. It was noted that on an identified date in March, 2016 resident #040 entered the room of resident #048 while a Personal Support Worker (PSW) was present. The residents became involved in an altercation. This resulted in resident #048 sustaining a minor physical injury.
The CI report was reviewed and contained information as above. The DOC was interviewed and confirmed that resident #048 was physically abused by resident #040.

The records of residents #040 and #047 were reviewed. The review of resident #040's record revealed information as above.
Resident #047 resided in the secure home area and was cognitively impaired. Resident #047 had a history of responsive behaviors. It was noted that on an identified date in March, 2016 resident #047 entered the room of resident #040 and an altercation occurred. Resident #040 sustained minor physical injuries. CI report was reviewed and contained information as above. It also included multiple incidents of altercations between resident #040 and co-residents from December 2015 to March, 2016. The DOC was interviewed and confirmed that resident #040 was physically abused by resident #047.

Despite the interventions implemented by the home residents' #040 and #042 were involved in altercations which resulted in physical injury. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been rescinded:CO# 001

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 residents including resident #040 are protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff, to be implemented voluntarily.

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

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

Findings/Faits saillants :

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

1. The record of resident #006 was reviewed. They were noted to have an area of altered skin integrity on an identified date in September, 2016. The plan of care for this resident indicated that the area of altered skin integrity was the same in one area and had deteriorated in another area. The weekly assessments completed on two identified dates in November, 2016 indicated that the wound had deteriorated. Assessments since an identified date in November, 2016 as well as interview with registered staff #105 indicated that the wound was healing. Staff and others involved in the different aspects of care failed to collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The record of resident #043 was reviewed. It was noted on an identified date in March, 2013 the physiotherapist assessed the resident and indicated that they were non-weight bearing. The progress notes of October, 2013 indicated that the resident was assessed by the physiotherapist and they needed identified exercises and or treatments. However, as a result of noncompliance the resident was discharged from physiotherapy services. Further review of the resident's record indicated that on an identified date in March, 2016 the resident was observed by restorative staff #117 who determined that the resident was safe to use an identified lift. Staff were to use the lift to place the resident in the bath chair. The resident was sent to the hospital on an identified date in May, 2016 as a result of an injury. There was no documentation found in the resident's record indicating that the physiotherapist assessed the resident's weight bearing status between October, 2013 and May, 2016. The physiotherapist assessed the resident in May, 2016 post-hospitalization in response to a referral.
The physiotherapist was interviewed and reported information as above. The DOC was interviewed and confirmed that the staff did not collaborate with each other in the assessment of the resident related to transferring and weight bearing, so that their assessments were integrated and consistent with and complemented each other. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of all residents including residents #006 and #043 collaborate with each other, in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: 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 has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails were addressed, including height and latch reliability as evidenced by:

The record of resident #006 was reviewed including the Personal Assistance Service Devise (PASD) Bed Rail Assessment dated May, 2016 and the care plan. The PASD Bed Rail Assessment indicated that the resident did not move when in bed. However, a co-resident's responsive behaviors placed resident #006 at risk while they were in bed. The care plan focus Personal Assistance Service Device (PASD), created in July, 2011 and revised in May, 2016 noted that the resident required two three-quarter bed rails to increase their ability to engage in activities of daily living. The mobility focus included interventions indicating that the resident required the assistance of staff for all position changes when in bed and the staff were to put two three-quarter rails up when the resident was in bed to aid with positioning. Further review of the skin focus indicated that the resident used a specified surface on their bed. No documentation was found in the resident's record indicating that the resident was assessed and that their bed system was evaluated The home was requested to produce evidence of resident assessment and of their bed system evaluation. This documentation was not provided by the home. The Restorative Care Coordinator was interviewed and confirmed that two three-quarter bed rails were used for resident #006 for the purposes indicated in their record and that an assessment and bed system evaluation was not completed for resident #006. They also reported that the bed rails were removed from the bed of resident #006. [s. 15. (1)]

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 bed rails are used, all residents are assessed and their bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents; steps are taken to prevent residents' entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls as evidenced by:

Resident #004 was noted to have an identified intervention implemented. The home's policy and procedures Head Injury Routine, Policy 5-RS-270 last updated in November, 2016 indicated that the Head Injury Routine will be carried out for 24 hours post fall. The results of the assessment will be documented on the Glasgow Coma Scale (GSC) form. The frequency of conducting assessment for residents with evidence of a head injury as follows: first four hours, every 60 minutes and next 20 hours, a minimum of every four hours, for a total of 24 hours.

A) The resident had an unwitnessed fall on an identified date in November, 2016 at

an identified time. The Glasgow Coma Scale was initiated at the time of the fall; however, was not completed again until almost three hours later. The assessments for second and third hours were not completed. The next three assessments were noted as: resident refused but the time not identified; at 15 hours post fall and 27 hours post fall hours.
The Fall Risk Assessment was also not completed as confirmed with the RAI Coordinator. The RAI Coordinator also confirmed that the post fall assessments Glasgow Coma Scale (Head Injury Routine) were not completed as required.

B) The resident had an unwitnessed fall on an identified date in November, 2016 at an identified time. The Glasgow Coma Scale was not initiated until almost three hours later; however, was not completed again until almost eight hours post fall and almost 12 hours post fall. There were no further assessments completed. The assessments for one hour post fall and two hours post fall were not found to be completed. The 16 hours post fall and the 20 hours post fall assessments were not completed.
Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the post fall assessments Glasgow Coma Scale (Head Injury Routine) were found to be not completed either.

C) The resident had an unwitnessed fall on an identified date in November, 2016 at an identified time. The Glasgow Coma Scale was initiated at that time; however, assessments for one hour post fall, two hours post fall and three hours post fall were not found. Two assessments were missing for the first four hour requirement of once per hour for four hours. There was no time documented for the assessment completed after the initial identified time and the next one was documented at over four hours post fall and then for almost eight hours post fall, over 12 hours post fall and almost 24 hours post fall.
Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the post fall assessments Glasgow Coma Scale (Head Injury Routine) were not completed as required.

D) The resident had an unwitnessed fall on an identified date in November, 2016 at an identified time. The Glasgow Coma Scale was initiated at that time and completed for the next four hours for the first four hours as per policy; however, the next assessment was completed at almost 11 hours post fall. The six hours post fall assessment and 15 hours post fall assessments were not completed.
Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed

that the post fall assessments Glasgow Coma Scale (Head Injury Routine) were not completed as required.

E) The resident had an unwitnessed fall on an identified date in December, 2016 at an identified time The Glasgow Coma Scale was initiated at almost one hour post fall, with subsequent assessments completed at almost three hours post fall and over four hours post fall. The next scheduled assessment was not completed. The next assessment was completed at over eight hours post fall and almost 12 hours post fall and not again until the following day at over 24 hours post fall.
Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the post fall assessments Glasgow Coma Scale (Head Injury Routine) were not completed as required. [s. 49. (2)]

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 when any resident including resident #004, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment as evidenced by:

i) The record of resident #005 was reviewed and it was noted that they had a small area of altered skin integrity on an identified date in October, 2016. As confirmed with the RAI Coordinator, the area was not assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

ii) The record of resident #005 was reviewed and it was noted that they had a small area of altered skin integrity on an identified date in December, 2016. As confirmed with the RAI Coordinator, the area was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been

reassessed at least weekly by a member of the registered nursing staff, if clinically indicated as evidenced by:

A) The record of resident #003 was reviewed and it was noted that they had a two identified areas of altered skin integrity on an identified date in March, 2016. As confirmed with the RAI Coordinator, weekly skin assessments were not completed on thirteen identified dates between March, 2016 and August 2016. The area of altered skin integrity was noted to have resolved on an identified date in August, 2016.

B) The record of resident #006 was reviewed and they were noted to have an area of altered skin integrity on an identified date in September, 2016. As confirmed with the RAI Coordinator, weekly skin assessments were not completed on an identified date in September, 2016 and on an identified date in October, 2016. Interview with registered staff #105 reported that the area was currently improving.

C) i) The record of resident #005 was reviewed and they were noted to have an area of altered skin integrity upon return from hospital in July, 2016. As confirmed with the RAI Coordinator on December 21, 2016, weekly skin assessments were not completed three weeks in August 2016. One week in September, 2016; one week in September, 2016; five weeks in October, 2016 and three weeks in November, 2016.
ii) Resident #005 was noted to have an area of altered skin integrity in October, 2016. As confirmed with the RAI Coordinator, the weekly skin assessments for one week in October, 2016 and three weeks in November, 2016 were not completed.
iii) Resident #005 was noted to have an area of altered skin integrity in December, 2016. As confirmed with the RAI Coordinator, the weekly assessment for one week in December, 2016 was not completed.
Residents #003, #006 and #005 were exhibiting altered skin integrity and the areas of altered skin integrity were not reassessed at least weekly by a member of the registered nursing staff. [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, all residents including resident #005 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 and to ensure that all residents including residents #003, #005 and #006, who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented as evidenced by:

The record of resident #001 who had an identified intervention was reviewed for November and December 2016. Specific monitoring records were not completed for every shift.
The DOC was interviewed and confirmed that the personal care interventions provided to resident #001 were not always documented. [s. 30. (2)]

Issued on this 27 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
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Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELODY GRAY (123) - (A1)

Inspection No. / No de l'inspection : 2016_558123_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 034429-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Feb 27, 2017;(A1)

Licensee / Titulaire de permis :
ST. JOSEPH'S HEALTH SYSTEM
99 Wayne Gretzky Parkway, BRANTFORD, ON, N3S-6T6

LTC Home / Foyer de SLD :
ST JOSEPH'S LIFECARE CENTRE
99 WAYNE GRETZKY PARKWAY, BRANTFORD, ON, N3S-6T6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : DERRICK BERNARDO

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

Ministère 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

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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 soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 27 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY - (A1)

Service Area Office /
Bureau régional de services : Hamilton