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

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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 #/ No de registre	Type of Inspection / Genre d'inspection
Jun 11, 2018;	2018_563670_0003 (A1)	001881-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village at St. Clair
1800 Talbot Road WINDSOR ON N9H 0E3

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

Ontario

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

Amended by DEBRA CHURCHER (670) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date was changed to July 13 2018 as the home requested and extension for education and auditing.

Issued on this 12 day of June 2018 (A1)

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

Original report signed by the inspector.

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

Amended by DEBRA CHURCHER (670) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 31, February 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15 and 16, 2018.

The following complaints were inspected during this Resident Quality Inspection (RQI):

Log# 027938-17 Infoline #54424-LO related to alleged abuse and neglect.

Log# 002775-18 Infoline #55363-LO related to alleged abuse, neglect and retaliation.

The following follow up to Orders of the Inspector was completed during this RQI:

Log# 017743-17 Follow up to order #002 from Complaint Inspection #2017_418615_0013.

The following Critical Incident System (CIS) reports were inspected during this RQI:

Log# 029401-17 CIS #3046-000065-17 related to resident to resident abuse and responsive behaviours.

Log# 013995-17 CIS #3046-000022-17 related to resident to resident abuse and responsive behaviours.

Log# 018930-17 CIS #3046-000042-17 related to resident to resident abuse and responsive behaviours.

Log# 029293-17 CIS #3046-000064-17 related to resident to resident abuse and responsive behaviours.

Log# 027106-17 CIS #3046-000060-17 related to resident to resident abuse and responsive behaviours.

Log# 025058-17 CIS# 3046-000057-17 related to resident to resident abuse and responsive behaviours.

Log# 023600-17 CIS# 3046-000053-17 related to resident to resident abuse and responsive behaviours.

Log# 001224-18 CIS# 3046-000004-18 related to alleged staff to resident abuse.

Log# 016962-17 CIS# 3046-000036-17 related to alleged staff to resident abuse.

Log# 022420-17 CIS# 3046-000048-17 related to a missing narcotic.

Log# 019504-17 CIS# 3046-000039-17 related to a fall with injury.

Log# 020978-17 CIS# 3046-000046-17 related to a fall with injury.

Log# 020434-17 CIS# 3046-000041-17 related to a fall with injury.

Log# 001974-18 CIS# 3046-000006-18 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with more than forty residents, Residents' Council representative, Family Council representative, the General Manager, the Director of Care, two Assistant Directors of Care, three Resident Assessment Instrument Coordinators, the Recreation Manager, the Administrative Coordinator, three Neighborhood Coordinators, one Kinesiologist, one Chaplain, more than three family members, two Registered Nurses, 21 Registered Practical Nurses, 22 Personal Support Workers, two

Housekeepers, one Dietitian and one private worker.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication rooms, medication

administration and medication count, the provision of resident care, recreational activities, dining, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records and the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Trust Accounts

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

11 WN(s)
4 VPC(s)
3 CO(s)
1 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. 52. (2)	CO #002	2017_418615_0013	670

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. A) The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date at a specific time.

During a phone interview on a specific date, RPN #160 stated that they recalled the incident and was able to describe the incident.

In an interview with Neighborhood Coordinator (NC) #158 on a specific date, they stated they received a market place message on a specific date, from RPN #160 with specific concerns. NC #158 shared that when they received the market place message they reported it to the Director of Care (DOC) and an investigation was started.

Inspector #670 reviewed the home's internal investigation with NC #158. The inspector observed that the investigation included interviews with PSWs #159, #161, #162, #164, and RPN #160. The inspector reviewed the market place message sent from RPN #160 to NC#158 and the interview with RPN #160.

NC #158 stated that once the interviews were completed that it was decided that there was conclusive evidence of abuse and specific actions were taken.

In an interview with General Manager (GM) #100 on a specific date, they stated that through investigation the home concluded that abuse had occurred and the home took specific actions.

B) The home contacted Ministry of Health and Long Term Care-Home after hours pager report #18252 on a specific date, and submitted a Critical Incident System (CIS) report.

On a specific date, an interview and review of the home's internal investigation was completed with Director of Care (DOC) #101 who stated that they were at the facility on the date of the incident.

DOC #101 stated that PSW #129 had reported to RPN #133 that they had found a specific concern. DOC #101 began an internal investigation. Through investigation DOC #101 determined that a specific event had occurred and the home took specific action.

In an interview with General Manager (GM) #100 on a specific date, they stated that a thorough investigation had been completed and the home had concluded

that abuse had occurred and the home took specific actions in relation to the incident.

The licensee has failed to ensure that resident's were protected from abuse by anyone and that residents were not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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 has failed to ensure that a resident exhibiting 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.

A) During the home's Resident Quality Inspection (RQI), it was identified through record review and a staff interview that a specific resident had altered skin integrity.

A specific resident's Treatment Administration Record (TAR) was reviewed on a specific date and included treatment for a the altered skin integrity.

A specific resident's clinical record was reviewed and showed that no specific weekly assessments or observations had been completed for a specific time frame.

RPN #125 was interviewed and shared that specific assessments were completed weekly for altered skin integrity and should be documented in the clinical record.

RPN #128 acknowledged that resident #056 should have had specific assessments, for altered skin integrity, for a specific time frame, but did not have the assessments completed.

Resident Assessment Instrument (RAI) Coordinator #118, who was also the home's Wound Care Lead, stated that the specific resident should have had specific assessments, for altered skin integrity, for a specific time frame, but did not have the assessments completed.

DOC #101 was interviewed and stated that specific assessments were completed weekly in PCC. DOC #101 acknowledged that a specific weekly assessment was missing for the specific resident for a specific time frame.

B) Review of a specific resident's clinical record showed that the resident had altered skin integrity, aquired on a specific date.

The specific resident's clinical record showed that there was no specific weekly assessment related to the specific resident's altered skin integrity for a total of ten weekly assessments not being completed within a specific time frame.

DOC #101 acknowledged that ten specific weekly assessments were not completed for the specific resident and should have been.

The licensee has failed to ensure that a resident exhibiting 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. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) A specific resident's Minimum Data Set (MDS) assessment dated for a specific date, showed that the resident experienced a specific condition.

The home noted the condition on a specific date and notified the physician who assessed the resident on a specific date and ordered specific interventions.

Review of the clinical record for the specific resident showed that the resident had not been monitored related to the specific condition on twenty four specific shifts.

Review of a specific document on the unit that was utilized to monitor specific conditions, showed that the resident was not added to the list.

In an interview on a specific date, Director of Care (DOC) #101 stated that the specific resident should have been added to the specific document used for monitoring specific conditions and should have been monitored and assessed every shift for a specific time frame and was not.

B) A specific resident's Multiple Data Set (MDS) assessment dated for a specific date, showed that the resident experienced a specific condition.

Review of the specific resident's clinical record showed that the resident was treated for a specific condition for a specific amount of time.

Review of the specific resident's progress notes for a specific time frame showed that the resident was not monitored related to a specific condition for 8 shifts.

In an interview with the ADOC #119, they shared that the specific resident should have been monitored every shift related to a specific condition and this should have been documented in the clinical record.

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (5) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10 s. 68 (2) states that every licensee of a long-term care home shall ensure that the programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

Review of clinical records in the home showed that twenty one residents had not had an annual height obtained in 2017.

DOC #101 stated that all resident's should have a height completed annually.

The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with. [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 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, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the satisfaction survey, and in acting on its results.

A) Review of the Family Council meeting minutes for a specific time frame which showed no reference to the yearly satisfaction survey.

An interview was conducted on a specific date, with the home's Chaplain #143 who acted as the Assistant to the Family Council. Chaplain #143 stated that the home had not involved the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

An interview was conducted on a specific date, with the home's Family Council President (FCP) #144 for the year of 2017. FCP #144 stated that they had no recollection if the Family Council had been involved with the satisfaction survey in any way and had no recollection if the Family Council had been made aware of the results.

An interview was conducted on a specific date, with the General Manager (GM) #100. GM #100 stated that the home did not include Family Council in any part of the satisfaction survey and the results of the survey or plans of correction were not shared with the Council.

B) Review of the Residents' Council meeting minutes for a specific time frame showed one reference to the yearly satisfaction survey in a specific meeting, with reference to reviewing the recreation department results.

An interview was conducted on a specific date, with the home's Recreation Director #142 who acted as the Assistant to the Residents' Council. Recreation Director #142 stated that the home had not involved the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. The only involvement of the Residents' Council was the review of the Recreation results.

An interview was conducted on a specific date, with a specific resident. The specific resident stated that they could not recall the if Resident's council had been involved or included in the satisfaction survey and was not aware of the results.

An interview was conducted on a specific date, with General Manager (GM) #100. GM #100 stated that the home did not include Residents' Council in any part of the satisfaction survey and the results of the survey or plans of correction were not shared with the Council.

The licensee has failed to ensure that they sought the advice of the Residents'

Council and the Family Council, if any, in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice.

A)Review of the Family Council meeting minutes for a specific period showed no reference to the yearly satisfaction survey.

An interview was conducted on a specific date, with the home's Chaplain #143 who acted as the Assistant to the Family Council. Chaplain #143 stated that the home had not provided the Family Council with the satisfaction survey results and had not sought the advice of the Family Council regarding the survey.

An interview was conducted on a specific date, with the home's Family Council President (FCP) #144 for the year of 2017. FCP #144 stated that they had no recollection if the home shared the results of the satisfaction survey or sought the advice of the Family Council.

An interview was conducted on a specific date, with General Manager (GM) #100. GM #100 stated that the home did not include Family Council in any part of the satisfaction survey, the results of the survey had not been shared with the Family Council and the home did not seek the advice of the Family Council.

B) Review of the Residents' Council meeting minutes for a specific time frame, showed one reference to the yearly satisfaction survey in the October 24, 2017 meeting, with reference to reviewing the recreation department results.

An interview was conducted on February 9, 2018, with the home's Recreation Director #142 who acted as the Assistant to the Residents' Council. Recreation Director #142 stated that the only involvement of the Residents' Council was the review of the Recreation results at a specific meeting. Recreation Director #142 stated that the home did not share all of the results with the Residents' Council and did not seek the advice of the Residents' Council.

An interview was conducted on a specific date, with a specific resident who stated that they could not recall if the Residents' Council had been made aware of the

satisfaction survey results and could not recall the if home sought the advice of the Resident's Council regarding the results.

An interview was conducted on a specific date, with General Manager (GM) #100. GM #100 stated that the home did not include Residents' Council in any part of the satisfaction survey, the results of the survey had not been shared with the Residents' Council and the home did not seek the advice of the Residents' Council.

The licensee has failed to make available to the Residents' Council and Family Council, the results of the satisfaction survey in order to seek the advice of the Residents' Council and the Family Council about the survey. [s. 85. (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 licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. The licensee shall ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

During the RQI, a medication incident report involving a specific resident was reviewed by the inspector.
The following information was included in a specifically dated medication incident report:
- On a specified date, a physician ordered a specific medication three times daily (TID) for a specific resident.
- At a specific time on a specific date, the medication had not been delivered to the home by the external pharmacy service provider.
- RPN #157 proceeded to borrow medication from another resident and mistakenly administered the incorrect medication to the resident.

RPN #157 told the inspector that they administered the the incorrect medication in error and that RPN #167 advised them that borrowing medication from another resident was permitted when the newly ordered medication had not yet been delivered by the pharmacy. RPN #157 said they were not sure if the home's emergency medication box contained the required medication and that they did not check the home's stock of emergency medications.

RPN #167 shared with the inspector that the home's medication administration policy did not allow registered staff to borrow medications from one resident to another and that the home's emergency stock medication box included the required medication.

DOC #101 agreed that borrowing medication from one resident to another was not an acceptable practice within the home and that on a specific date at a specific time, RPN #157 administered the incorrect medication to the specified resident.

The licensee has failed to ensure that resident #028 was administered a drug that had been prescribed to them. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

During the RQI, a medication incident report involving a specific resident was reviewed by the inspector.
The following information was included in a medication incident report:
- On a specific date, a physician ordered a specific medication for the specific resident.
-At a specific time on a specific date, the specific medication had not been delivered to the home by the external pharmacy service provider.
-RPN #157 proceeded to borrow medication from a different resident and mistakenly borrowed and administered the wrong medication to a specific resident.

The clinical record for the specific resident was reviewed by the Inspector. The record did not include documentation about the medication incident and documentation related to monitoring of the resident post incident.

RPN #157 told the Inspector that they had self-reported the medication error concerning the specific resident to DOC #101 and thought they had also documented the incident and follow-up monitoring in the clinical record of the specific resident. The RPN further said post incident they took the specific resident's blood pressure and found it to be within normal limits. RPN #157 was not able to describe other follow-up tasks to the Inspector that may have been completed after the medication incident.

DOC #101 shared with the Inspector that the concern related to the absence of documentation by RPN #157 related to the medication error with the specific resident had been discussed with the RPN post incident and that RPN #157 acknowledged that they should have documented the incident and follow-up care in the progress note section of PCC, the residents' electronic clinical record.

The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (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, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 11. iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

At a specific time on a specific date, during the initial tour of the home, Inspector #144 observed a medication cart in the hallway on the Gosfield resident home area between the dining room and lounge area with the PCC electronic resident clinical record program opened to the clinical record for a specific resident.

A RN and RPN were not observed in the area where the medication cart & PCC system was observed. At the time of the observation, there were 14 residents and one activity personnel in the lounge area as well as one resident and visitor in the dining room.

At a specific time on the same date, RPN #104 returned to the medication cart and told the inspector they had gone to a resident's room located on another hallway within the same resident home area. The RPN further acknowledged their awareness that the PCC system should have been closed before leaving the medication cart unattended.

DOC #101 shared with the inspector that the expectation and practice in the home was for registered personnel to close the PCC resident clinical record system when they were leaving the medication cart unattended.

The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 11. iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

s. 24. (2) Every person is guilty of an offence who includes in a report to the Director under subsection (1) information the person knows to be false. 2007, c. 8, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date at a specific time. The critical incident occurred on a specific date at a specific time, the CIS report indicated that a specific event had occurred. The incident was overheard and witnessed by Registered Practical Nurse (RPN) #160.

In an interview on a specific date, NC #158 stated they received a market place

message from RPN #160 with concerns about an occurance, however they did not access their market place messages until the end of the day on a specific date. NC #158 stated that RPN #160 did not report the incident to the RN or any other management on call. NC #158 shared that when they found the market place message they reported it to the DOC and an investigation was started. NC #158 stated that it would have been the expectation that the RN would have been notified and would have notified the manager on call for direction regarding notification of the Minitsry of Health and Long-Term Care.

On a specific date at a specific time an interview was conducted with Director of Care (DOC) #101 who stated that for any incidents of a specific nature staff were expected to notify the RN immediately who would then notify management as soon as possible. DOC #101 stated that if after hours or on a weekend or holiday the home would notify the Ministry of Health and Long-Term Care (MOHLTC) via the info line and management would follow up with the CIS report on the next business day.

In an interview with General Manager (GM) #100 on a specific date, they stated that the home should have notified the MOHLTC as soon as possible on a specific date and did not.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection was initiated as a specific resident was identified to have a specific condition according to the most recent Minimum Data Set (MDS) assessment in stage one of this Resident Quality Inspection.

The inspector reviewed the specific resident's MDS assessment completed on admission on a specific date. The assessment showed a specific level of functioning and a specific level of assistance required.

The inspector reviewed the specific resident's next MDS assessment completed on a specific date. The assessment showed a specific level of functioning and a specific level of assistance required which was changed from the previous assessment.

In an interview with the DOC #101 they shared that a specific assessment should have been completed during a specific time frame when a change in condition was noted but was not.

The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly itemized written statement was provided to the resident, or to a person acting on behalf of a resident with respect to money held by the licensee in trust for the resident, that included the balance of the resident's funds as of the date of the statement.

A specific resident was admitted to the home on a specific date.

During stage one of the RQI, the POA for a specific resident told the inspector that on the resident's admission to the home, a specific amount was deposited into a trust account on the resident's behalf and that the trust account had not been used. The POA for the specific resident also said that they had not received a statement from the home with respect to the specific balance in the resident's trust account.

Administrative Coordinator #124 shared that resident trust account statements were sent to resident POA's monthly and that the POA for the specific should have received them each month since the specific resident's admission to the home.

Review of the Monthly Statement of Resident Trust Account for the specific resident confirmed a specific amount was deposited into the trust account on a specific date and that there was a specific balance in the trust account on, a specific date.

Administrative Coordinator #124 further advised that a list of monthly trust account statements sent by mail to resident POA's was not maintained and that review of the resident's account revealed the balance in the account and that there had been no activity on the account since the initial deposit on a specific date.

The licensee has failed to ensure that a quarterly itemized written statement was provided to a person acting on behalf of a specific resident with respect to money held by the licensee in trust for the resident. [s. 241. (7) (f)]

Issued on this 12 day of June 2018 (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
Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by DEBRA CHURCHER (670) - (A1)

Inspection No. / No de l'inspection : 2018_563670_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001881-18 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 11, 2018;(A1)

Licensee / Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5

LTC Home / Foyer de SLD : The Village at St. Clair
1800 Talbot Road, WINDSOR, ON, N9H-0E3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Julie D'Alessandro

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 Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_303563_0036, CO #001;

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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically the licensee must:
a) ensure the identified residents and all other residents are protected from abuse by anyone and are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001, from inspection #2016_303563_0036, served on November 14, 2016, with a compliance date of November 30, 2016.

The licensee was ordered to achieve compliance to ensure residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee was ordered to achieve compliance by ensuring education of the home's policy titled "Personal Expression Program using The Layered Natured Framework and the P.I.E.C.E.S Approach" is provided to all staff members.

The licensee completed the required education of the home's policy titled "Personal

Expression Program using The Layered Natured Framework and the P.I.E.C.E.S Approach" was provided to all staff members.

The licensee failed to ensure residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on a specific date at a specific time.

During a phone interview on a specific date, RPN #160 stated that they recalled the incident and was able to describe the incident.

In an interview with Neighborhood Coordinator (NC) #158 on a specific date, they stated they received a market place message on a specific date, from RPN #160 with specific concerns. NC #158 shared that when they received the market place message they reported it to the Director of Care (DOC) and an investigation was started.

Inspector #670 reviewed the home's internal investigation with NC #158. The inspector observed that the investigation included interviews with PSWs #159, #161, #162, #164, and RPN #160. The inspector reviewed the market place message sent from RPN #160 to NC#158 and the interview with RPN #160.

NC #158 stated that once the interviews were completed that it was decided that there was conclusive evidence of abuse and specific actions were taken.

In an interview with General Manager (GM) #100 on a specific date, they stated that through investigation the home concluded that abuse had occurred and the home took specific actions.

B) The home contacted Ministry of Health and Long Term Care-Home after hours pager report #18252 on a specific date, and submitted a Critical Incident System (CIS) report.

On a specific date, an interview and review of the home's internal investigation was

completed with Director of Care (DOC) #101 who stated that they were at the facility on the date of the incident.

DOC #101 stated that PSW #129 had reported to RPN #133 that they had found a specific concern. DOC #101 began an internal investigation. Through investigation DOC #101 determined that a specific event had occurred and the home took specific action.

In an interview with General Manager (GM) #100 on a specific date, they stated that a thorough investigation had been completed and the home had concluded that abuse had occurred and the home took specific actions in relation to the incident.

The licensee has failed to ensure that resident's were protected from abuse by anyone and that residents were not neglected by the licensee or staff. [s. 19. (1)] (670)

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

May 30, 2018

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2017_418615_0013, CO #001;

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

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

Order / Ordre :

The licensee must be compliant with r. 50. (2) (b) (iv) of the Regulation.

Specifically the licensee must:
a) ensure that identified residents and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
b) ensure that all skin and wound assessments are documented in the resident's clinical record.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001, from inspection #2017_418615_0013, served on August 2, 2017, with a compliance date of August 31 2017.

The licensee was ordered to ensure that resident #001, #002, #003 and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that the resident exhibiting 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.

A) During the home's Resident Quality Inspection (RQI), it was identified through record review and a staff interview that a specific resident had altered skin integrity.

A specific resident's Treatment Administration Record (TAR) was reviewed on a specific date and included treatment for a the altered skin integrity.

A specific resident's clinical record was reviewed and showed that no specific weekly assessments or observations had been completed for a specific time frame.

RPN #125 was interviewed and shared that specific assessments were completed weekly for altered skin integrity and should be documented in the clinical record.

RPN #128 acknowledged that a specific resident should have had specific assessments, for altered skin integrity, for a specific time frame, but did not have the assessments completed.

Resident Assessment Instrument (RAI) Coordinator #118, who was also the home's Wound Care Lead, stated that the specific resident should have had specific assessments, for altered skin integrity, for a specific time frame, but did not have the assessments completed.

DOC #101 was interviewed and stated that specific assessments were completed weekly in PCC. DOC #101 acknowledged that a specific weekly assessment was missing for the specific resident for a specific time frame.

B) Review of a specific resident's clinical record showed that the resident had altered skin integrity, aquired on a specific date.

The specific resident's clinical record showed that there was no specific weekly assessment related to the specific resident's altered skin integrity for a total of ten weekly assessments not being completed within a specific time frame.

DOC #101 acknowledged that ten specific weekly assessments were not completed for the specific resident and should have been.

The licensee has failed to ensure that a resident exhibiting 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. [s. 50. (2) (b) (iv)]

(669)

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

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

Jul 13, 2018(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with r. 229. (5) of the Regulation.

Specifically the licensee must ensure that on every shift, symptoms indicating the presence of infection in residents are monitored, the symptoms are recorded and that immediate action is taken as required.

Grounds / Motifs :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) A specific resident's Minimum Data Set (MDS) assessment dated for a specific

date, showed that the resident experienced a specific condition.

The home noted the condition on a specific date and notified the physician who assessed the resident on a specific date and ordered specific interventions.

Review of the clinical record for the specific resident showed that the resident had not been monitored related to the specific condition on twenty four specific shifts.

Review of a specific document on the unit that was utilized to monitor specific conditions, showed that the resident was not added to the list.

In an interview on a specific date, Director of Care (DOC) #101 stated that the specific resident should have been added to the specific document used for monitoring specific conditions and should have been monitored and assessed every shift for a specific time frame and was not.

B) A specific resident's Multiple Data Set (MDS) assessment dated for a specific date, showed that the resident experienced a specific condition.

Review of the specific resident's clinical record showed that the resident was treated for a specific condition for a specific amount of time.

Review of the specific resident's progress notes for a specific time frame showed that the resident was not monitored related to a specific condition for 8 shifts.

In an interview with the ADOC #119, they shared that the specific resident should have been monitored every shift related to a specific condition and this should have been documented in the clinical record.

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (5) (a)]
(670)

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

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

Jul 23, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DEBRA CHURCHER - (A1)

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

Service Area Office / Bureau régional de services : London