Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2016	2016_229213_0013	008403-16	Follow up

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 13, 14, 15, 20, 21, 2016

This follow up inspection was completed related to order #001 (mandatory education) issued January 4, 2016 in a critical incident inspection with a compliance date of March 31, 2016, inspection #2015_303563_0055, log #012005-15.

This inspection was also completed related to order #001 (staffing plan evaluated), #002 (clear direction in care plan), #004 (immediately reporting abuse), #010 issued as a director referral with a compliance order (dealing with complaints), #011 (care

plan based on an assessment of resident needs and preferences), #012 (care provided as per plan), #013 (staff access to care plan), #014 (care plan reviewed and revised when care needs changed, and #016 (resident right to be cared for in a manner consistent with needs), all issued March 8, 2016 in the Resident Quality Inspection, inspection #2016_229213_0005, log #001309-16.

A critical incident inspection (#2016_229213_0014, log #004562-16 and 005961-16), and two complaint inspections (#2016_303563_0011, log #008504-16 and #2016_303563_0012, log #009805-16) were completed concurrently while in the home completing the follow up inspections.

The following findings of non-compliance identified in complaint inspection #2016_303563_0012, log #009805-16 are issued in this report:
Compliance order #002 related to LTCHA, 2007 c.8, s. 6 (1)(c)
Compliance order #003 related to LTCHA, 2007 c.8, s. 6 (2)
Compliance order #004 related to LTCHA, 2007 c.8, s. 6 (7)
Compliance order #005 related to LTCHA, 2007 c.8, s. 3 (1)(4)

The following finding of non-compliance identified in complaint inspection #2016_303563_0011, log #008504-16 is issued in this report:
Compliance order #002 related to LTCHA, 2007 c.8, s. 6 (1)(c)

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer, Administrator, the Acting Administrator, the Director of Care, the Acting Director of Care, the Assistant Director of Care, the Geriatric Clinical Nurse Specialist, a Physician, the Resident Assessment Instrument (RAI) Coordinator, the Director of Recreation, the Receptionist, the Registered Dietitian, two Registered Nurses, six Registered Practical Nurses, twelve Personal Support Workers, over sixteen residents and over five family members.

The Inspectors also made observations and reviewed health records, education records, policies and procedures, internal investigation records, the home's complaints record, resident and family council meeting minutes, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing
Training and Orientation

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

- **3 WN(s)**
- **1 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #004	2016_229213_0005	213
O.Reg 79/10 s. 31. (3)	CO #001	2016_229213_0005	213
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #014	2016_229213_0005	213
LTCHA, 2007 S.O. 2007, c.8 s. 6. (8)	CO #013	2016_229213_0005	213
LTCHA, 2007 S.O. 2007, c.8 s. 76. (1)	CO #001	2015_303563_0055	213

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, the date any response was provided and any response by the complainant. The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in

determining what improvements were required in the home and a written record was kept of each review and the date of the improvements made in response.

Record review of the progress notes for resident #002 and critical incident #3407-000002 -16 revealed this resident reported alleged staff to resident abuse during care on an identified date and had responsive behaviours.

Staff interview with the Geriatric Clinical Nurse Specialist (GCNS) #105 on April 14, 2016, confirmed that she was advised of resident #002's report of alleged abuse on the date it was reported by the Registered Nurse in the building. The GCNS reported that the Registered Practical Nurse on the unit received the initial complaint from the resident and reported this to the Registered Nurse. The GCNS confirmed that she reported the incident to the Ministry of Health and Long Term Care that day, and completed a critical incident report to the Ministry of Health and Long Term Care regarding the complaint. The GCNS confirmed that she completed an internal investigation related to the critical incident, interviewed staff and spoke with the family of resident #002. The GCNS confirmed that a Client Services Response (CSR) form had been completed and the internal investigation was documented, however, she was unable to find the investigation notes at that time. The CSR form and interview notes were located by the home on April 15, 2016.

Record review of the home's Client Services Response form binder on April 14, 2016 revealed no documentation regarding the complaint received from resident #002. Record review of the home's Complaint Log and analysis of complaints revealed the complaint received from resident #002 was not documented in the log and was not included in the quarterly analysis of complaints for trends and improvements needed in the home.

Staff interview with the Acting Director of Care on April 15, 2016 and with the Acting Administrator on April 20, 2016 confirmed that they had not been made aware of the complaint from resident #002. As that Client Services Response form had not been included in the binder and had not been logged, it had not been included in the quarterly analysis of complaints for trends and improvements required.

Staff interview with the Geriatric Clinical Nurse Specialist #105 on April 15, 2016, confirmed that resident #002 voiced a complaint to staff which was then reported to her. She completed an investigation but failed to include the complaint in the home's Client Services Response form binder, it was not included in the log of complaints and was not

included in the analysis for trends and improvements required in the home as per the home's expectations. [s. 101.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

Record review of the current plan of care for resident #064 revealed three specific interventions to be in place when other residents were wandering in that hallway.

Staff interview with Personal Support Worker (PSW) #118 on April 20, 2016, revealed they don't use one of the interventions any longer for resident #064, it's not needed. PSW #118 shared that there is another resident on the unit will occasionally wander into resident #064's room and one of the interventions is to be in place when resident #064 was in their room. PSW #118 confirmed that this intervention was not in place at the time of the interview.

Observations on April 20, 2016 at 1400 hours, revealed resident #064 was in their room in the bathroom, and none of the three identified interventions were in place. At that time, resident #043 was in the hallway of resident #064.

Staff interview with the Assistant Director of Care (ADOC) #104, who was walking by the room of resident #064 at the time, confirmed that the resident was in the room and the three identified interventions were not in place. She confirmed that resident #043 was wandering in that hallway at that time and no staff were in the hallway to know that this resident was there, or put the interventions in place. The ADOC confirmed the plan of care did not provide clear direction to the staff as they would not know when residents were in wandering in resident #064's hallway in order to know when to implement the interventions. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

Observation of resident #007's room on April 20, 2016 at 1450 hours revealed a sign posted in the resident's room which had conflicting information, directions crossed out and hand written additions regarding identified interventions for resident #007.

Progress notes revealed staff were aware that directions in the resident's room was changed by family and conflicted with physician's orders.

Staff interview with PSWs #120, #121, #122 and RPN #124 on April 20, 2016 confirmed the bedside instructions for resident #007 did not provide clear or accurate direction to the PSW staff providing care to the resident. The RPN #124 confirmed the sign was not updated according to the instructions received by the physician.

Staff interview with the Director of Care (DOC) #117 on April 20, 2016 at 1500 hours confirmed the sign was confusing and the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

Record review of the Complaint Information Report # IL-43748-LO submitted to the Ministry of Health on March 19, 2016 revealed the complainant believed there was a very serious communication breakdown in regards to the resident #006's care plan.

a) Record review of the current care plan for resident #006 had a specific diet order to be provided as desired.

Staff interview with Personal Support Worker (PSW) #120, #121, #122, Registered Practical Nurse (RPN) #124 and RPN #131 revealed the plan of care for resident #006 related to the resident's intake of food and fluids was confusing and did not provide clear direction. PSW and registered nursing staff shared they were given conflicting information regarding the resident's diet. PSW #120 and PSW #121 confirmed the "as desired" directive was unclear.

Record review of the diet order for resident #006 on an identified date revealed a specific diet order to be given only as requested by the resident.

Staff interview with the Registered Dietitian (RD) #126 confirmed that the meal or snack was to be offered to the resident and staff were not to wait for the resident to "desire" it. The RD confirmed the care plan direction was not clear.

b) Record review of the "Physician's Order Form" on an identified date indicated a specific health care directive.

Record review of the most recent "Three Month Medication Review" revealed two different conflicting health care directives on the same form for resident #006.

Staff interview with Registered Practical Nurse (RPN) #131 confirmed the plan of care did not set out clear directions to staff and others related to the health care directive

orders for resident #006. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the current plan of care for resident #043 revealed the resident was incontinent of both bowel and bladder, required incontinence products, and extensive assistance with toileting and personal care.

Record review of assessments completed in Point Click Care for resident #043 revealed the most recent bladder and bowel continence assessments were completed in 2014 and indicated the resident was continent of bowel and bladder.

Staff interviews with Personal Support Worker #118 and Registered Practical Nurse #119 confirmed that resident #043 is incontinent of both bowel and bladder, wears incontinence products, is toileted and requires extensive assistance with toileting and personal hygiene.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that plans of care related to continence and toileting should have been based on a current assessment of the resident's needs. [s. 6. (2)]

5. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the current plan of care for resident #045 revealed no indication of bed rail use.

Record review of assessments completed for resident #045 revealed the most recent bed rail use assessment indicated both quarter bed rails used for bed mobility.

Staff interviews with Personal Support Worker (PSW) #123 confirmed that resident #045 preferred to have both quarter rails in use when in bed. The PSW confirmed resident #045 was able to move independently in bed with the assistance of two quarter bed rails and that the kardex did not indicate the use of bed rails for resident #045.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that plans of care related to bed rail use should have been based on a current assessment of the resident's needs and preferences. [s. 6. (2)]

6. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Health record review for resident #007 revealed 96 entries of documentation of pain in various sites and of various degrees of severity over a 15 month period. Progress notes over a nine day period revealed the resident had daily complaints of pain in a specified limb, discolouration, swelling, and deceased function. Health record review further revealed pain management interventions were ineffective. No pain assessments were completed over this 15 month period.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator #106 revealed a Pain Assessment was to be completed in Point Click Care (PCC) for resident #007.

The home failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident when no pain assessments were completed for 15 months while the resident expressed ongoing pain, or when pain management proved ineffective. [s. 6. (2)]

7. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the health record for resident #016 revealed this resident had eight falls over a two month period.

Record review of the health record for resident #016 revealed the most recent physiotherapy note indicated specific instructions related to transferring.

Record review of the current plan of care for resident #016 revealed 2 side rails were to be up to aid in bed mobility. There was no indication of the physiotherapist's specific instructions related to transferring.

Record review of assessments completed in Point Click Care revealed the most recent bed rail use assessment for resident #016 completed and indicated bed rails were not used.

Staff interview with Personal Support Worker (PSW) #127 confirmed that resident #016 used two side rails when in bed.

Staff interview with the Acting Administrator #101, the Administrator #116 and the Director of Care #117 on April 21, 2016, confirmed that the plan of care regarding the use of bed rails and transferring interventions for resident #016 should have been based on an assessment of this resident's needs and preferences related to bed rail use and transfers; in needing the falls mat removed prior to transfer. [s. 6. (2)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the Complaint Information Report # IL-43893-LO submitted to the Ministry of Health on an identified date revealed resident #007 was to have a medical appliance applied to a specific extremity and the home was not complying with this.

Record review of a family communication progress note on an identified date revealed resident #007's family was in the home and voiced a complaint noting that the medical appliance was found on the wrong extremity, despite the instructions for staff.

Record review of the current care plan revealed specific directions related to applying the medical appliance to a specific extremity as well as instructions regarding care of the medical appliance.

Staff interview with Registered Practical Nurse (RPN) #124 confirmed they had knowledge of the incident whereby the resident was found with the medical appliance applied to the wrong extremity and confirmed it was the home's expectation that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

9. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Interview with resident #024 on April 21, 2016, revealed the resident was dissatisfied with the home's incontinence products, they were not effective, and not meeting the resident's needs. Resident #024 shared that the staff provided the assistance that the resident required, front line staff were very responsive, when the resident rang the call bell, staff responded quickly.

Interview with Personal Support Worker (PSW) #127 revealed the incontinence products in the home did not meet resident #024's needs despite the significant care provided.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that the plan of care for resident #024 should have been reviewed and revised when the care related to continence care was not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and plans of care are reviewed and revised when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure the resident's right to be properly cared for in a manner

consistent with his or her needs was fully respected and promoted.

a) Complaint Information Report # IL-43893-LO submitted to the Ministry of Health on March 30, 2016 revealed resident #007 complained of pain, discomfort, and changes in function in an identified extremity. Staff reported that the extremity was assessed and there were no concerns. Resident #007's family took the resident to the hospital for further assessment as they were concerned for the resident's health.

Health record for resident #007 revealed pain, swelling, and decreased function in an identified extremity over a 7 month time period. There were also a number of progress notes documenting concerns regarding the extremity voiced from the family of resident #007 over a seven month time period. The resident's family transferred the resident to hospital and the resident was admitted for a period of time with a significant diagnosis requiring treatment. On return from hospital, the resident continued to experience pain with pain management interventions ineffective.

Health record for resident #007 revealed 96 entries of documentation of pain in various sites and of various degrees of severity over a 15 month period. No pain assessments were completed over this 15 month period. The home did not properly care for resident # 007 in a manner consistent with pain and health needs, as well as the need for acute care interventions and assessment in hospital.

b) Family communication progress notes and an interview with the family of resident #007 revealed the family voiced a number of concerns during the annual care conference including foot care that wasn't being provided in the home due to a contract issue with the provider. The home did not properly care for resident #007 in a manner consistent with foot care needs, as well as the resident's family was not made aware of the home's issue with the foot care provider so that alternative foot care arrangements could be made.

c) Interview with the family of resident #007 and record review of the home's incontinence products process revealed the family requested a change in incontinence products and this change was not implemented for 17 days after the family's pursuit of the issue eight days after the initial request.

Interview with the Assistant Director of Care (ADOC) on April 13, 2016 revealed the product change request was in the wrong book, which caused the delay. The home did not fully respect and promote resident #007's right to be properly cared for in a manner

consistent with continence needs.

The licensee failed to fully respect and promote resident #007's right to be properly cared for in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 13th day of May, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2016_229213_0013
Log No. / Registre no:	008403-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 11, 2016
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Richardson

To SHARON FARMS & ENTERPRISES LIMITED, 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_229213_0005, CO #010;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee will ensure that the home's complaints process is completed in full, in a timely manner, for every verbal and written complaint received, effective immediately and will include a documented record of:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.
2. The documented record is reviewed and analyzed for trends at least quarterly; the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response.

Grounds / Motifs :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, the date any response was provided and any response by the complainant. The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements were required in the home and a written record was kept of each review and the date of the improvements made in response.

Record review of the progress notes for resident #002 and critical incident #3407-000002-16 revealed this resident reported alleged staff to resident abuse during care on an identified date and had responsive behaviours.

Staff interview with the Geriatric Clinical Nurse Specialist (GCNS) #105 on April 14, 2016, confirmed that she was advised of resident #002's report of alleged abuse on the date it was reported by the Registered Nurse in the building. The GCNS reported that the Registered Practical Nurse on the unit received the initial complaint from the resident and reported this to the Registered Nurse. The GCNS confirmed that she reported the incident to the Ministry of Health and Long Term Care that day, and completed a critical incident report to the Ministry of Health and Long Term Care regarding the complaint. The GCNS confirmed that she completed an internal investigation related to the critical incident, interviewed staff and spoke with the family of resident #002. The GCNS confirmed that a Client Services Response (CSR) form had been completed and the internal investigation was documented, however, she was unable to find the investigation notes at that time. The CSR form and interview notes were located by the home on April 15, 2016.

Record review of the home's Client Services Response form binder on April 14, 2016 revealed no documentation regarding the complaint received from resident #002. Record review of the home's Complaint Log and analysis of complaints revealed the complaint received from resident #002 was not documented in the log and was not included in the quarterly analysis of complaints for trends and improvements needed in the home.

Staff interview with the Acting Director of Care on April 15, 2016 and with the Acting Administrator on April 20, 2016 confirmed that they had not been made aware of the complaint from resident #002. As that Client Services Response form had not been included in the binder and had not been logged, it had not been included in the quarterly analysis of complaints for trends and improvements required.

Staff interview with the Geriatric Clinical Nurse Specialist #105 on April 15, 2016, confirmed that resident #002 voiced a complaint to staff which was then reported to her. She completed an investigation but failed to include the complaint in the home's Client Services Response form binder, it was not included in the log of complaints and was not included in the analysis for trends and improvements required in the home as per the home's expectations.

The scope of this issue was isolated. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on March 6, 2015, issued again as a compliance order on April 30, 2015, re-issued as a compliance order on January 4, 2016 with a compliance date of January 31, 2016 and re-issued as a compliance order with a director referral on March 8, 2016 during the Resident Quality Inspection with a compliance date of April 4, 2016. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_229213_0005, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that plan of care sets out clear directions to staff and others who provide direct care to all residents and specifically:
a) That the plan of care sets out clear direction for resident #006 related to diet,eating and health care directives.
b) That the plan of care sets out clear direction for resident #007 related to elevating the resident's legs.
c) That the plan of care sets out clear direction for resident #064 related to the residents room door, the use of a wanderguard strip, and the use of a door alarm.

Grounds / Motifs :

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

Record review of the Complaint Information Report # IL-43748-LO submitted to the Ministry of Health on March 19, 2016 revealed the complainant believed there was a very serious communication breakdown in regards to the resident #006's care plan.

a) Record review of the current care plan for resident #006 had a specific diet order to be provided as desired.

Staff interview with Personal Support Worker (PSW) #120, #121, #122, Registered Practical Nurse (RPN) #124 and RPN #131 revealed the plan of care for resident #006 related to the resident's intake of food and fluids was confusing and did not provide clear direction. PSW and registered nursing staff shared they were given conflicting information regarding the resident's diet. PSW #120 and PSW #121 confirmed the "as desired" directive was unclear.

Record review of the diet order for resident #006 on an identified date revealed a specific diet order to be given only as requested by the resident.

Staff interview with the Registered Dietitian (RD) #126 confirmed that the meal or snack was to be offered to the resident and staff were not to wait for the resident to "desire" it. The RD confirmed the care plan direction was not clear.

b) Record review of the "Physician's Order Form" on an identified date indicated a specific health care directive.

Record review of the most recent "Three Month Medication Review" revealed two different conflicting health care directives on the same form for resident #006.

Staff interview with Registered Practical Nurse (RPN) #131 confirmed the plan of care did not set out clear directions to staff and others related to the health care directive orders for resident #006. (563)

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

Observation of resident #007's room on April 20, 2016 at 1450 hours revealed a sign posted at the head of the bed which had conflicting information, directions crossed out and hand written additions regarding identified interventions for resident #007.

Progress notes revealed staff were aware that directions on the sign above the resident's bed was changed by family and conflicted with physician's orders.

Staff interview with PSWs #120, #121, #122 and RPN #124 on April 20, 2016 confirmed the bedside instructions for resident #007 did not provide clear or accurate direction to the PSW staff providing care to the resident. The RPN

#124 confirmed the sign was not updated according to the instructions received by the physician.

Staff interview with the Director of Care (DOC) #117 on April 20, 2016 at 1500 hours confirmed the sign was confusing and the plan of care did not set out clear directions to staff and others who provide direct care to the resident. (563)

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

Record review of the current plan of care for resident #064 revealed three specific interventions to be in place when other residents were wandering in that hallway.

Staff interview with Personal Support Worker (PSW) #118 on April 20, 2016, revealed they don't use one of the interventions any longer for resident #064, it's not needed. PSW #118 shared that there is another resident on the unit will occasionally wander into resident #064's room and one of the interventions is to be in place when resident #064 was in their room. PSW #118 confirmed that this intervention was not in place at the time of the interview.

Observations on April 20, 2016 at 1400 hours, revealed resident #064 was in their room in the bathroom, and none of the three identified interventions were in place. At that time, resident #043 was in the hallway of resident #064.

Staff interview with the Assistant Director of Care (ADOC) #104, who was walking by the room of resident #064 at the time, confirmed that the resident was in the room and the three identified interventions were not in place. She confirmed that resident #043 was wandering in that hallway at that time and no staff were in the hallway to know that this resident was there, or put the interventions in place. The ADOC confirmed the plan of care did not provide clear direction to the staff as they would not know when residents were in wandering in resident #064's hallway in order to know when to implement the interventions.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did

have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on March 6, 2015 and again on April 28, 2015. It was issued as a compliance order on March 8, 2016 during the Resident Quality Inspection with a compliance date of April 4, 2016.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_229213_0005, CO #011;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee will ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences for all residents and specifically:
a) The plan of care for resident #007 is based on an assessment of the resident's needs and preferences related to pain and pain management.
b) The plan of care for resident #016 is based on an assessment of the resident's needs and preferences related to the use of bed rails and transferring interventions.
c) The plan of care for resident #043 is based on an assessment of the resident's needs and preferences related to continence.
d) The plan of care for resident #045 is based on an assessment of the resident's needs and preferences related to the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the health record for resident #016 revealed this resident had eight falls over a two month period.

Record review of the health record for resident #016 revealed the most recent physiotherapy note indicated transfer status remains two staff assistance. Staff must use walker and transfer belt for staff and resident safety and must also remove fall mats to allow for the resident to safely and easily pick feet up when

turning. Resident does need time and cannot be rushed during the transfer.

Record review of the current plan of care for resident #016 revealed:
- Provide 2 staff pivot transfer for all transfers
- Encourage resident to use her walker with all transfers
- Ensure 2 side rails are up to aid in bed mobility
- Ensure bed is to be in the lowest position at all times when resident is in bed
- Ensure fall mats remain on either side of bed when resident is in bed
- Bed pad alarm checked each shift by staff to ensure safety

Record review of assessments completed in Point Click Care revealed the most bed rail use assessment for resident #016 completed and indicated bed rails were not used.

Staff interview with Personal Support Worker (PSW) #127 confirmed that resident #016 used two side rails when in bed. The PSW confirmed that bed alarms were used and falls mats were put on the floor beside the bed as this resident was cognitively impaired, would get out of bed unassisted, and was a high risk for falls.

Staff interview with the Acting Administrator #101, the Administrator #116 and the Director of Care #117 on April 21, 2016, confirmed that the plan of care regarding the use of bed rails and transferring interventions for resident #016 should have been based on an assessment of this resident's needs and preferences related to bed rail use and transfers; in needing the falls mat removed prior to transfer.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on April 28, 2015 and April 30, 2015. It was issued as a compliance order on March 8, 2016 during the Resident Quality Inspection with a compliance date of April 4, 2016. (213)

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Health record review for resident #007 revealed 96 entries of documentation of pain in various sites and of various degrees of severity over a 15 month period. Progress notes over a nine day period revealed the resident had daily complaints of pain in a specified limb, discolouration, swelling, and deceased function. Health record review further revealed pain management interventions were ineffective. No pain assessments were completed over this 15 month period.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator #106 revealed a Pain Assessment was to be completed in Point Click Care (PCC) for resident #007.

The home failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident when no pain assessments were completed for 15 months while the resident expressed ongoing pain, or when pain management proved ineffective. (213)

3. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the current plan of care for resident #045 revealed no indication of bed rail use.

Record review of assessments completed for resident #045 revealed the most recent bed rail use assessment indicated both quarter bed rails used for bed mobility.

Staff interviews with Personal Support Worker (PSW) #123 confirmed that resident #045 preferred to have both quarter rails in use when in bed. The PSW confirmed resident #045 was able to move independently in bed with the assistance of two quarter bed rails and that the kardex did not indicate the use of bed rails for resident #045.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that plans of care related to bed rail use should have been based on a current assessment of the resident's needs and preferences.

(213)

4. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Record review of the current plan of care for resident #043 revealed the resident was incontinent of both bowel and bladder, required incontinence products, and extensive assistance with toileting and personal care.

Record review of assessments completed in Point Click Care for resident #043 revealed the most recent bladder and bowel continence assessments were completed in 2014 and indicated the resident was continent of bowel and bladder.

Staff interviews with Personal Support Worker #118 and Registered Practical Nurse #119 confirmed that resident #043 is incontinent of both bowel and bladder, wears incontinence products, is toileted and requires extensive assistance with toileting and personal hygiene.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that plans of care related to continence and toileting should have been based on a current assessment of the resident's needs. (213)

5. . (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_229213_0005, CO #012;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee will ensure that the care set out in the plan of care is provided to the resident as specified in the plan for all residents and specifically:
a) The care set out in the plan of care for resident #007 related to the use of compression stockings.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the Complaint Information Report # IL-43893-LO submitted to the Ministry of Health on an identified date revealed resident #007 was to have a medical appliance applied to a specific extremity and the home was not complying with this.

Record review of a family communication progress note on an identified date revealed resident #007's family was in the home and voiced a complaint noting that the medical appliance was found on the wrong extremity, despite the physician's order and instructions posted on a sign in the resident's room.

Record review of the current care plan revealed specific directions related to applying the medical appliance to a specific extremity as well as instructions regarding care of the medical appliance.

Staff interview with Registered Practical Nurse (RPN) #124 confirmed they had knowledge of the incident whereby the resident was found with the medical

appliance applied to the wrong extremity and confirmed it was the home's expectation that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

9. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Interview with resident #024 on April 21, 2016, revealed the resident was dissatisfied with the home's incontinence products, they were not effective, and not meeting the resident's needs. Resident #024 shared that the staff provided the assistance that the resident required, front line staff were very responsive, when the resident rang the call bell, staff responded quickly.

Interview with Personal Support Worker (PSW) #127 revealed the incontinence products in the home did not meet resident #024's needs despite the significant care provided.

Record review of the current plan of care for resident #024 revealed clear directions related to the resident's incontinence needs.

Interview with the Administrator #116 and the Director of Care #117 on April 21, 2016 confirmed the home's expectation that the plan of care for resident #024 should have been reviewed and revised when the care related to continence care was not effective.

The scope of this issue was isolated. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on April 28, 2015 and on April 30, 2015, and again on June 19, 2015. It was issued as a compliance order on March 8, 2016 during the Resident Quality Inspection with a compliance date of April 4, 2016.
(563)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_229213_0005, CO #016;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that residents' right to be properly cared for is respected and promoted.

Specifically, the plan must include but is not limited to how the home's management team will ensure communication between home staff, residents and families as appropriate and specific to individual resident needs related to:
1. Pain, pain assessments and pain management.
2. Physician's recommendations and orders.
3. Resident/Family/Power of Attorney requests regarding care and changes in services.
4. Changes in services provided by or contracted by the home.
5. Changes in resident requirements related to incontinence products.
6. Changes in resident care, needs, services, etc.

The plan will also include how this plan and expectations of the home related to communication will be communicated to all staff of the home, residents and families.

Please submit the plan in writing to Rhonda Kukoly, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Ave, 4th Floor, London, ON, N6A 5R2, by email, at rhonda.kukoly@ontario.ca, by May 20, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

a) Complaint Information Report # IL-43893-LO submitted to the Ministry of Health on March 30, 2016 revealed resident #007 complained of pain, discomfort, and changes in function in an identified extremity. Staff reported that the extremity was assessed and there were no concerns. Resident #007's family took the resident to the hospital for further assessment as they were concerned for the resident's health.

Health record for resident #007 revealed pain, swelling, and decreased function in an identified extremity over a 7 month time period. There were also a number of progress notes documenting concerns regarding the extremity voiced from the family of resident #007 over a seven month time period. The resident's family

transferred the resident to hospital and the resident was admitted for a period of time with a significant diagnosis requiring treatment. On return from hospital, the resident continued to experience pain with pain management interventions ineffective.

Health record for resident #007 revealed 96 entries of documentation of pain in various sites and of various degrees of severity over a 15 month period. No pain assessments were completed over this 15 month period. The home did not properly care for resident # 007 in a manner consistent with pain and health needs, as well as the need for acute care interventions and assessment in hospital.

b) Family communication progress notes and an interview with the family of resident #007 revealed the family voiced a number of concerns during the annual care conference including foot care that wasn't being provided in the home due to a contract issue with the provider. The home did not properly care for resident #007 in a manner consistent with foot care needs, as well as the resident's family was not made aware of the home's issue with the foot care provider so that alternative foot care arrangements could be made.

c) Interview with the family of resident #007 and record review of the home's incontinence products process revealed the family requested a change in incontinence products and this change was not implemented for 17 days after the family's pursuit of the issue eight days after the initial request.

Interview with the Assistant Director of Care (ADOC) on April 13, 2016 revealed the product change request was in the wrong book, which caused the delay. The home did not fully respect and promote resident #007's right to be properly cared for in a manner consistent with continence needs.

The licensee failed to fully respect and promote resident #007's right to be properly cared for in a manner consistent with their needs.

The scope of this issue was isolated. The severity of the issue was determined to be actual harm and risk. The home did have a history of non-compliance with this sub-section of the legislation. It was issued as a compliance order on March 8, 2016 during the Resident Quality Inspection with a compliance date of April 4,

2016. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

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

Issued on this 11th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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