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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 26, 2015;	2014_247508_0020 (A3)	H-000771-14	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

PEEL MANOR
525 MAIN STREET NORTH BRAMPTON ON L6X 1N9

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

ROSEANNE WESTERN (508) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested amendments to the report and the orders. The licensee has requested more detailed information around the development of the medical directives.

The following are changes made to the report and the orders:

CO#001 - 4. In consultation with the Medical Director and the Professional Advisory Committee develop medical directives to ensure that:
- residents with Diabetes Mellitius and residents with Diabetes Mellitius that have a change in condition that may affect their blood sugar levels resulting in hypo/hyperglycemic reactions,
-the ten most commonly prescribed drugs administered at Peel Manor have directives to include blood sugar monitoring for potentially hypo/hyperglycemic reactions

Later that night, the registered staff obtained the resident's blood pressure (BP), heart rate (HR), oxygen level (O2 saturation), and temperature. She identified that the resident opened their eyes in response to their name but did not respond to her verbally. She had received a report from a PSW that the resident had to be changed earlier that shift due to a saturated brief.

Early the next morning, the registered staff re-assessed the resident's BP, HR, and O2 saturation level and indicated that the resident was not responding verbally but responded to tactile stimuli.

CO#005 - Later that night, the registered staff obtained the resident's blood pressure (BP), heart rate (HR), oxygen level (O2 saturation), and temperature. She identified that the resident opened their eyes in response to their name but did not respond to her verbally. She had received a report from a PSW that the resident had to be changed earlier that shift due to a saturated brief.

Early the next morning, the registered staff re-assessed the resident's BP, HR, and O2 saturation level and indicated that the resident was not responding

verbally but responded to tactile stimuli.

The NP and the RN consulted with the resident's regular Physician and received orders to initiate treatment. The resident's family member was contacted and had requested that resident #100 be treated at the home. Two hours later, there had been no change in the resident's condition and staff were still not able to obtain a blood sugar reading. Resident #100 remained unresponsive and was transferred to hospital. The resident was hospitalized for multiple days. After the resident was re-admitted to the home, the resident was diagnosed with an infection and treatment was initiated. The resident's health condition continued to decline and the resident was transferred back to the hospital. Two weeks later, resident #100 was re-admitted back to the home as the infection had resolved and the resident was deemed palliative. Resident #100 died three days later.

Issued on this 19 day of June 2015 (A3)

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

ROSEANNE WESTERN (508) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 24, 25, 26, July 29, August 1, 27, 2014.

This inspection was conducted concurrently with a Critical Incident inspection # H-000680-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Physician(MD), Supervisor of Care(SOC), Nurse Practitioner(NP), registered staff, Personal Support Workers (PSW), residents and family.

The following Inspection Protocols were used during this inspection:

Medication

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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

7 WN(s)
2 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents, including resident #100 and #101 were free from neglect by the licensee or staff in the home as defined in O.Reg. 79/10, s.5, where 'neglect' means the failure to provide a resident with the treatment, care,

services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident's Physician discontinued the medication due to low blood sugar levels. The Physician's order for glucose monitoring at this time, directed registered staff to check the resident's blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100's Physician ordered a medication, which has a commonly known side effect of increasing blood sugar levels. The resident started the medication the following day. On that same day, the Physician's order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician's order to monitor the resident's blood sugar was not reordered.

The resident's care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident's BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident's BS levels, nor did they take any steps to contact the resident's Physician about BS monitoring.

Commonly known signs and symptoms of hyperglycemia include, frequent urination and lethargy. In June 2014, the resident's family member reported to staff that she found the resident in a saturated brief. The next day, resident #100 was assessed by the registered staff due to reports of the resident being "sleepy". The registered staff took the resident's vital signs, but did not check the resident's blood sugar. The Nurse Practitioner on-call and the Physician on-call were notified, however, they were not the resident's regular NP or Physician and were not familiar with the resident.

The registered staff indicated during an interview that a thorough report had not been given to the NP and the MD on-call including the resident's diagnosis and current list of medications. There were no orders received. The registered staff member indicated that she was aware the resident had been on BS monitoring, however, did not obtain a BS level during her assessment nor identify the resident's symptoms as hyperglycemia.

Later that night, the registered staff obtained the resident's vital signs, but not their blood sugar. The registered staff identified that the resident could not respond verbally and that a PSW reported that the resident had to be changed earlier that shift due to a saturated brief.

Early the next morning, the registered staff re-assessed the resident's vital signs and indicated that the resident did not respond to verbal stimuli.

A few hours later, another registered staff member assessed the resident and identified that they were unresponsive. The resident's medication was held due to the resident being unresponsive and unable to swallow. The registered staff attempted to obtain a BS level, however, the BS reading indicated "HI". The NP came in to assess the resident and found the resident laying in bed, unresponsive. The resident's blood sugar level could not be obtained after several attempts with different glucometers as the blood sugar levels were too high for the glucometers to register.
The NP and the registered staff consulted the resident's regular Physician and received orders for treatment. Two hours later, there had been no change in the resident's condition and staff were still not able to obtain a blood sugar reading. Resident #100 remained unresponsive and was transferred to hospital. The resident was hospitalized for multiple days.

After the resident was re-admitted to the home, the resident was diagnosed with an infection and treatment was initiated. The resident's health condition continued to decline and the resident was transferred back to the hospital. Two weeks later, resident #100 was re-admitted back to the home and died three days later.

During the time the resident #100 was hospitalized, resident #100's family member spoke with the Supervisor of Care (SOC) requesting a record of the resident's blood sugar readings prior to the resident being transferred to hospital. The SOC became aware at this time that the resident's blood sugar readings had not been monitored, and that the resident had been hospitalized for hyperglycemia. Later that day, the SOC emailed the Director of Care (DOC) to report this occurrence. The DOC forwarded the same email to the Administrator the following morning.

A few days later, resident #100's family member spoke with the Supervisor of Care and requested a care conference with the Physician present. In June, 2014, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident's family members.

During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic. The resident's family member requested at this time that another Physician take over resident #100's care.

Six days later, the Director of Care sent an email to the registered staff informing them that there had been a very serious incident of a resident started on a new medication and the resident's blood sugar levels had not been monitored, resulting in negative consequences for the resident.
The email also stated that "as part of our nursing competencies we need to be aware of the side effects of the medications that we are administering and advocate for our residents. Should the Physician omit to writing an order for monitoring for those side effects such as blood sugar monitoring, blood pressure, specialized blood work, we as registered staff have to advocate on behalf of the resident and bring this to the attention of the Physician immediately for further clarification".

During an interview with the resident's attending Physician, the Physician indicated that he was not aware that the previous order had been cancelled and that the resident's blood sugars were not being monitored. It had not been brought to his attention until after the resident was hospitalized. The pharmacy servicing the home, indicated in an email to the Supervisor of Care, that when there was an order to change BS monitoring it trumps the previous order and the monitoring aspect needs to be sorted out by the nurse and MD, which was the reason the blood sugar monitoring order was stopped.

In July, 2014, two registered staff involved in resident #100's care during the time the resident was taking the newly prescribed medication were disciplined for not complying with their Regional Values, the College of Nurses Professional Standards, and the Residents' Bill of Rights which states "Every resident has the right not to be neglected by the licensee or staff".

B) In May, 2014, a PSW reported that resident #101 had a large purplish bruise on their forearm, which was observed while they were providing care. Staff were not able to determine the cause of the bruise and resident #101 was not able to communicate what had occurred due to their health conditions.

Later that same day, the resident was not able to weight-bear when staff transferred the resident to the toilet using the sit to stand lift. Resident #101's leg was swollen and

painful to touch, however, staff did not conduct a pain assessment. The resident did not receive any additional pain medication for this pain, only their regularly scheduled medication. A referral was left for the Physician.

The following day, the resident's leg remained swollen and painful. Resident #101 had difficulty weight bearing and ambulating in a wheelchair. Staff continued to transfer the resident using a sit to stand lift. There was no pain assessment completed or titration of pain medication. Another referral was completed for the Physician to assess as well as the Physiotherapist.

The next morning, the RPN noted the resident's leg to be bruised and swollen and requested a requisition be completed for an x-ray of the resident's leg. That afternoon, staff documented that the resident's leg was swollen and painful to touch. The Physician was contacted however, no orders were received including titration of pain medication, and the Physician did not go to the home to assess the resident.

The Nurse Practitioner(NP) was contacted and came in to assess the resident. The NP ordered the resident to go to the hospital for an x-ray and documented that the resident had facial grimacing and pain during this assessment. There were no changes in the resident's pain medication.

The resident was sent to hospital and returned to the home with a diagnosis of leg pain.
There was no x-ray report sent back to the home, only a report on a doppler that was done. Staff did not follow up with the hospital regarding the resident's x-ray results.

The following afternoon, the Physiotherapist (PT) assessed the resident and documented that the resident had facial expressions of pain and ordered the resident stay in bed until the x-ray report was received. The PT notified the nurse and the Supervisor of Care and requested they follow up on the x-ray results.

Later that day, the RPN spoke to the Physician and was informed that the resident sustained a fracture and that he would be in the next day to assess the resident. There were no new orders received, including pain medication.

The Physician came in the following day to assess resident #101 and ordered that the resident be sent to hospital. Two days later, the hospital advised the home that the resident required surgical repair of the fracture. The resident remained in hospital for five days.

The resident had on-going new pain related to a fractured femur. There were no identified pain assessments conducted, no interventions to relieve the resident's pain, including changes or additions to the regularly scheduled medication that the resident was taking for chronic pain. The resident did not receive a pain assessment until the inspector requested that the home conduct one during this inspection.

It was confirmed by the Supervisor of Care and the Director of Care that resident's #100 and #101 had been neglected by the home.

PLEASE NOTE: This evidence of non-compliance related to prevention of abuse, neglect and retaliation were found during inspection #2014_247508_0021 / H-000680-14 [s. 19. (1)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 001

WN #2: 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:
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 :

1. The licensee did not ensure that the rights of residents, including residents #100 and #101 were fully respected and promoted when residents #100 and #101 were not cared for in a manner consistent with their needs.

A) Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident's Physician discontinued the medication due to low blood sugar levels. The Physician's order for glucose monitoring at this time, directed registered staff to check the resident's blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100's Physician ordered a medication, which has a commonly known side effect of increasing blood sugar levels. The resident started this medication the following day. On that same day, the Physician's order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician's order to monitor the resident's blood sugar was not reordered.

The resident's care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident's BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident's BS levels, nor did they take any steps to contact the resident's Physician about BS monitoring.

B) In May, 2014, a PSW reported that resident #101 had a large purplish bruise on an identified body part, which was observed while they were providing care. Staff were not able to determine the cause of the bruise and resident #101 was not able to communicate what had occurred due to their health conditions.

Later that same day, the resident was not able to weight-bear when staff transferred

the resident to the toilet using the sit to stand lift. Resident #101's identified body part was swollen and painful to touch, however, staff did not conduct a pain assessment. The resident did not receive any additional pain medication for this pain, only their regularly scheduled medication. A referral was left for the Physician.

The following day, the resident's body part remained swollen and painful. Resident #101 had difficulty weight bearing and ambulating in a wheelchair. Staff continued to transfer the resident using a sit to stand lift. There was no pain assessment completed or titration of pain medication. Another referral was completed for the Physician to assess as well as the Physiotherapist.

The next morning, the RPN noted the resident's body part to be bruised and swollen and requested a requisition be completed for an x-ray of the resident's leg. That afternoon, staff documented that the resident's body part was swollen and painful to touch. The Physician was contacted however, no orders were received including titration of pain medication, and the Physician did not go to the home to assess the resident.

The Nurse Practitioner(NP) was contacted and came in to assess the resident. The NP ordered the resident to go to the hospital for an x-ray and documented that the resident had facial grimacing and pain during this assessment. There were no changes in the resident's pain medication.

The resident was sent to hospital and returned to the home with a diagnosis of pain. There was no x-ray report sent back to the home, only a report on a doppler that was done. Staff did not follow up with the hospital regarding the resident's x-ray results.

The following afternoon, the Physiotherapist (PT) assessed the resident and documented that the resident had facial expressions of pain and ordered the resident stay in bed until the x-ray report was received. The PT notified the nurse and the Supervisor of Care and requested they follow up on the x-ray results.

Later that day, the RPN spoke to the Physician and was informed that the resident sustained a fracture and that he would be in the next day to assess the resident. There were no new orders received, including pain medication.

The Physician came in the following day to assess resident #101 and ordered that the resident be sent to hospital. Two days later, the hospital advised the home that the resident required surgical repair. The resident remained in hospital for

five days.

The resident had on-going new pain related to a fracture. There were no identified pain assessments conducted, no interventions to relieve the resident's pain, including changes or additions to the regularly scheduled medication that the resident was taking for chronic pain. The resident did not receive a pain assessment until the inspector requested that the home conduct one during this inspection.

It was confirmed by the Supervisor of Care and the Director of Care that resident's #100 and #101 had not been cared for in a manner consistent with their needs.

PLEASE NOTE: This evidence of non-compliance related to the resident's right to be cared for in a manner consistent with their needs were found during inspection #2014_247508_0021 / H-000680-14 [s. 3. (1) 4.]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's care set out in the plan of care, including resident #100's, was provided to the resident as specified in the plan.

Resident #100's written plan of care directed staff to monitor resident for signs and symptoms of hyperglycemia/hypoglycemia - tremors, shaking, confusion, headache, irritability, hunger, nausea, vomiting, cool/clammy/pale skin, diaphoresis, report extreme thirst, frequent urination, abdominal pain, fatigue, blurred vision, dry flushed skin, shallow rapid breathing. Monitor Lab and check blood sugar twice weekly (randomly) and when necessary (PRN). Monitor blood sugar as ordered and PRN. Report any abnormalities to the Physician.

Resident #100's regularly scheduled medication to maintain their blood sugar (BS) level was discontinued. A week later, the resident was ordered a new medication to treat a skin condition, which has a commonly known side effect of increasing blood sugar levels. The resident started this medication the following day.

The resident was not monitored as specified in the written plan of care which resulted in the resident becoming unresponsive and hyperglycemic. As a result, the resident was transferred to hospital and treated for hyperglycemia.

It was confirmed by the Supervisor of Care and the Director of Care that it was the expectation that staff provide care to residents as directed in their plan of care. [s. 6. (7)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that when residents, including resident #100 and #101 were taking any drug or combination of drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A) Resident #100 was taking regularly scheduled medication to manage their diabetes. The medication was discontinued due to low blood sugar levels and daily blood sugar level monitoring was implemented for seven days. After the seven days, the order for daily BS monitoring was discontinued and the resident's blood sugar levels were not monitored for ten days.

In order to treat a skin condition, resident #100 started taking a new medication, which has a commonly known side effect of increasing blood sugar levels. Staff failed to monitor the resident for side effects of this medication or monitor the resident for signs and symptoms of hyperglycemia or hypoglycemia. No one took the resident's blood sugar level until the resident was found unresponsive on a date in June, 2014.

B) Resident #101 was taking regularly scheduled analgesics to manage their chronic pain. In May, 2014, the resident sustained a fracture due to an unwitnessed incident. The resident exhibited pain and staff continued to administer the resident's regular analgesics despite it being ineffective. The resident continued to experience pain regularly for multiple days until transferred to hospital for surgery. Throughout these identified days, staff failed to monitor the resident's response or document the effectiveness of the pain medication.

It was confirmed by the Director of Care that resident #100 and resident #101 were not monitored for side effects or effectiveness of their medications.

PLEASE NOTE: This evidence of non-compliance related to the monitoring and documenting of resident's responses and effectiveness of medication were found during inspection #2014_247508_0021 / H-000680-14 [s. 134. (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A3)The following order(s) have been amended:CO# 004

WN #5: 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).

Findings/Faits saillants :

1. The licensee did not ensure that when they had reasonable grounds to suspect that improper or incompetent treatment of care for resident #100, had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident's Physician discontinued the medication due to low blood sugar levels. The Physician's order for glucose monitoring at this time, directed registered staff to check

the resident's blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100's Physician ordered a new medication, which has a commonly known side effect of increasing blood sugar levels. The resident started the new medication the following day. On that same day, the Physician's order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician's order to monitor the resident's blood sugar was not reordered.

The resident's care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident's BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident's BS levels, nor did they take any steps to contact the resident's Physician about BS monitoring.

Commonly known signs and symptoms of hyperglycemia include, frequent urination and lethargy. In June 2014, the resident's family member reported to staff that she found the resident in a saturated brief. The next day, resident #100 was assessed by the registered staff due to reports of the resident being "sleepy". The registered staff took the resident's vital signs, but did not check the resident's blood sugar. The Nurse Practitioner on-call and the Physician on-call were notified, however, they were not the resident's regular NP or Physician and were not familiar with the resident.

The registered staff indicated during an interview that a thorough report had not been given to the NP and the MD on-call including the resident's diagnosis and current list of medications. There were no orders received. The registered staff member indicated that she was aware the resident had been on BS monitoring, however, did not obtain a BS level during her assessment nor identify the resident's symptoms as hyperglycemia as she was focused on the resident's elevated blood pressure.

Later that night, the registered staff obtained the resident's blood pressure (BP), heart rate (HR), oxygen level (O2 saturation), and temperature. The registered staff identified that the resident could not respond verbally and that a PSW reported that the resident had to be changed earlier that shift due to a saturated brief.

Early the next morning, the registered staff re-assessed the resident's BP, HR, and O2 saturation level and indicated that the resident did not respond to verbal stimuli.

A few hours later, another registered staff member assessed the resident and identified that she was unresponsive. The resident's medication was held due to the resident being unresponsive and unable to swallow. The registered staff attempted to obtain a BS level, however, the BS reading indicated "HI". The NP came in to assess the resident and found the resident laying in bed, unresponsive. The resident's blood sugar level could not be obtained after several attempts with different glucometers as the blood sugar levels were too high for the glucometers to register.

The NP and the registered staff consulted the resident's regular Physician and received orders for treatment. Two hours later, there had been no change in the resident's condition and staff were still not able to obtain a blood sugar reading. Resident #100 remained unresponsive and was transferred to hospital. The resident was hospitalized for several days.

During the time the resident #100 was hospitalized, resident #100's family member spoke with the Supervisor of Care (SOC) requesting a record of the resident's blood sugar readings prior to the resident being transferred to hospital. The SOC became aware at this time that the resident's blood sugar readings had not been monitored, and that the resident had been hospitalized for hyperglycemia. Later that day, the SOC emailed the Director of Care (DOC) to report this occurrence. The DOC forwarded the same email to the Administrator the following morning.

A few days later, resident #100's family member spoke with the Supervisor of Care and requested a care conference with the Physician present. In June, 2014, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident's family members. During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic. The resident's family member requested at this time that another Physician take over resident #100's care.

During an interview with the resident's attending Physician, the Physician indicated that he was not aware that the previous order had been cancelled and that the resident's blood sugars were not being monitored. It had not been brought to his attention until after the resident was hospitalized. The pharmacy servicing the home, indicated in an email to the Supervisor of Care, that when there was an order to change BS monitoring it trumps the previous order and the monitoring aspect needs to be sorted out by the nurse and MD, which was the reason the blood sugar monitoring order was stopped.

The Director of Care sent an email to the registered staff informing them that there had been a very serious incident of a resident started on a new medication and the resident's blood sugar levels had not been monitored, resulting in negative consequences for the resident.
The email also stated that "as part of our nursing competencies we need to be aware of the side effects of the medications that we are administering and advocate for our residents. Should the Physician omit to writing an order for monitoring for those side effects such as blood sugar monitoring, blood pressure, specialized blood work, we as registered staff have to advocate on behalf of the resident and bring this to the attention of the Physician immediately for further clarification".

Six days after the care conference, the resident was diagnosed with an infection and was started on an antibiotic. The resident's health condition continued to decline and the resident was transferred back to the hospital the following day for increased congestion, low oxygen levels and lethargy.

In June, 2014, the Inspector arrived at the home to follow up on an unrelated Critical Incident and the complaint received from resident #100's family member regarding this incident. An interview with the Supervisor of Care indicated that she became aware of this incident six days after the resident was transferred to the hospital. The DOC and the Administrator both indicated during separate interviews, that they were informed the following day from the email sent from the SOC. The SOC and the DOC also indicated during the interviews that they had accepted responsibility for resident #100 becoming hyperglycemic and hospitalized.

In July, 2014, resident #100 was re-admitted back to the home and died three days later. The Social Worker informed the SOC and the Administrator that resident #100 passed away.

In July, 2014, after the resident passed away, two registered staff involved in resident #100's care during the time she was taking the newly prescribed medication were disciplined for not complying with their Regional Values, the College of Nurses Professional Standards, and the Residents' Bill of Rights which states "Every resident has the right not to be neglected by the licensee or staff"

In July, 2014, during a follow up inspection with Inspector #147, the Director of Care and the Supervisor of Care confirmed during an interview that they were aware of the seriousness of the incident. They acknowledged that resident #100 did not receive

the care required, and did not report that resident #100 was hospitalized for hyperglycemia to the Director on the date in June, 2014, when they became aware of the incident. The Administrator also confirmed during an interview, that when they became aware that the resident was hospitalized due to improper care, it should have been reported to the Director.

There was a complete failure of all staff, including the Supervisor of Care, the Director of Care, and the Administrator, to report to the Director. [s. 24. (1)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

In June, 2014, resident #100 was transferred to hospital and admitted for eight days for a diagnosis of hyperglycemia. Documentation in the resident records indicated the resident had been exhibiting symptoms of hyperglycemia for two days prior to transfer

to hospital. Resident #100's family member spoke with the Supervisor of Care requesting a record of the resident's blood sugar readings prior to the resident being transferred to hospital. The resident had a diagnosis of type 2 Diabetes Mellitus and had previous Physician orders for the monitoring of blood sugar levels which had been discontinued.

The Supervisor of Care became aware at this time, that the resident's blood sugar readings had not been monitored and that the resident had been hospitalized for hyperglycemia. Investigation into the cause of the incident was initiated by the Supervisor of Care when it was brought to their attention.

Later that day, the Supervisor of Care sent an email to the Director of Care informing her of this incident, and indicated in this email that the resident's blood sugar had not been monitored. The following day, the Director of Care forwarded this email to the Administrator to inform him of this incident.

A week later, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident's family members. During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic.

The home's policy #LTC1-05.01, titled, Prevention, Reporting and Elimination of Abuse/Neglect, in the Residents' Care and Services policy manual, defined "Neglect" as the failure to provide a resident with the treatment, care, services or assistance required for their health, safety or well-being of a resident. Neglect included a pattern of inaction that jeopardized the health, safety or well being of one or more residents.

Policy #LTC1-05.01, Prevention, Reporting and Elimination of Abuse/Neglect, directed any person who had first knowledge of abuse or suspected abuse should immediately inform a member of the centre's staff and the Director, Performance Improvement and Compliance Branch, MOHLTC.

In July, 2014, during a follow up inspection with Inspector #147, the Director of Care and the Supervisor of Care confirmed that they were aware of this incident and acknowledged that resident #100 did not receive the care required, but did not report it to the Director as directed in their policy. [s. 20. (1)]

Additional Required Actions:

CO # - 006 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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Resident #101 had a change in health status when staff identified that the resident's leg was painful, swollen, and the resident could not weight bear due to an undetermined event in May, 2014. The resident continued to exhibit signs and symptoms of pain regularly until transferred to hospital four days later.

The home's Pain Management Program directed staff to conduct a pain assessment utilizing a clinically appropriate instrument and to complete this when a resident exhibited a change in health status or pain had not relieved by initial interventions and upon readmission from hospital. The program also directed staff to conduct weekly pain assessments on residents on regular pain medications utilizing the Pain Monitoring Flow Sheet.

Staff did not conduct a pain assessment when, there was a change in the resident's health status, the resident exhibited signs and symptoms of pain, and when the resident returned from the hospital. Staff did not complete weekly pain assessments on resident #101 who was on regular pain medication.

It was confirmed by the Director of Care that the staff did not comply with the home's Pain Management Program. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

Issued on this 19 day of June 2015 (A3)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508) - (A3)
Inspection No. / No de l'inspection :	2014_247508_0020 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	H-000771-14 (A3)
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 26, 2015;(A3)
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	PEEL MANOR 525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JAMES EGAN

To THE REGIONAL MUNICIPALITY OF PEEL, 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) (b)

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 :

(A3)
The licensee shall prepare, submit and implement a corrective action plan to include the following:

1. review and revise the plan of care for resident #101 to include the resident s risk for falls, ensuring strategies and interventions are developed to minimize the risk of falls.

2. utilize a clinically appropriate instrument, that includes communication and assessment methods for residents who are cognitively impaired, including resident #101, immediately, quarterly, and when there is a change in the resident s condition. The assessments must be completed for witnessed and unwitnessed falls, and when pain is not relieved by initial interventions.

3. review and revise resident #101 s plan of care based on their completed pain assessment. If a pain management care plan is required, ensure strategies to manage pain including non-pharmacological interventions are included.

4. In consultation with the Medical Director and the Professional Advisory Committee, develop medical directives to ensure that:
-residents with Diabetes Mellitus and resident with Diabetes Mellitius that have a change in condition that may affect their blood sugar levels resulting in hypo hyperglycemic reactions have directives for blood sugar monitoring.
-the ten most commonly prescribed drugs administered at Peel Manor with the potential to effect blood sugar levels have directives to include blood sugar monitoring for potentially hypo hyperglycemic reactions.

5. Provide mandatory training to all registered nursing staff on:
-managing residents with Diabetes Mellitius
-the signs and symptoms of hyper and hypoglycemia
-medical directives for residents with Diabetes Mellitius
-monitoring of residents with changes to their medications, including responses to, and the effectiveness of the medication
-Pain and Falls Management Programs, Reporting and Elimination of Abuse Neglect Policy, including the reporting requirements

This plan is to be submitted to Roseanne Western via email at: roseanne.western@ontario.ca by May 30, 2015.

Grounds / Motifs :

(A3)
1. The licensee did not ensure that residents, including residents #100 and #101 were free from neglect by the licensee or staff in the home, as defined in O.Reg. 79 10, s.5, where neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident s Physician discontinued the medication due to low blood sugar levels. The Physician s order for glucose monitoring at this time, directed registered staff to check the resident s blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100 s Physician ordered a medication, which has a commonly known side effect of increasing blood sugar levels. The resident started the medication the following day. On that same day, the Physician s order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician s order to monitor the resident s blood sugar was not reordered.

The resident s care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident s BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident s BS levels, nor did they take any steps to contact the resident s Physician about BS monitoring.

Commonly known signs and symptoms of hyperglycemia include, frequent urination and lethargy. In June, 2014, the resident s daughter reported to staff that she found the resident in a saturated brief. The next day, resident #100 was assessed by the Registered Nurse (RN) due to reports of the resident being "sleepy". The RN took the resident s vital signs, but did not check the resident s blood sugar. The Nurse Practitioner on-call and the Physician on-call were notified, however, they were not the resident s regular NP or Physician and were not familiar with the resident.

The registered staff indicated during an interview that a thorough report had not been given to the NP and the MD on-call including the resident s diagnosis and current list of medications. There were no orders received. The RN indicated that she was aware the resident had been on BS monitoring, however, did not obtain a BS level during her assessment nor identify the resident s symptoms as hyperglycemia as she was focused on the resident s elevated blood pressure.

Later that night, the registered staff obtained the resident s vital signs but not the resident s blood sugar. She identified that the resident opened her eyes in response to the resident s name but did not respond to her verbally. She had received a report from a PSW that the resident had to be changed earlier that shift due to a saturated brief.
Early the next morning, the registered staff re-assessed the resident s vital signs and indicated that the resident was not responding verbally but responded to tactile stimuli.

A few hours later, the registered staff assessed the resident and identified that she was unresponsive. The registered staff held the resident s medication due to the resident being unresponsive and unable to swallow. The registered staff attempted to obtain a BS level, however, the BS reading indicated "HI". The NP came in to assess the resident and found the resident laying in bed, unresponsive. The resident s blood sugar level could not be obtained after several attempts with different glucometers as the blood sugar levels were too high for the glucometers to register.

The NP and the registered staff consulted the resident s regular Physician and received orders for treatment. The resident s family member was contacted and had requested that resident #100 be treated at the home. Two hours later, there had been no change in the resident s condition and staff were still not able to obtain a blood sugar reading. Resident #100 remained unresponsive and was transferred to hospital. The resident was hospitalized for multiple days. After the resident was re-admitted to the home, the resident was diagnosed with an infection and treatment was initiated. The resident s health condition continued to decline and the resident was transferred back to the hospital. Two weeks later, resident #100 was re-admitted back to the home as the infection had resolved and the resident was deemed palliative. Resident #100 died three days later.

A few days later, resident #100 s family member spoke with the Supervisor of Care (SOC) and requested a care conference with the Physician present. In June, 2014, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident s family. During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic. The resident s family member requested at this time that another Physician take over resident #100 s care.

Six days later, the Director of Care sent an email to the registered staff informing them that there had been a very serious incident of a resident started on a new medication and the resident s blood sugar levels had not been monitored, resulting in negative consequences for the resident.
The email also stated that "as part of our nursing competencies we need to be aware of the side effects of the medications that we are administering and advocate for our residents. Should the Physician omit to writing an order for monitoring for those side effects such as blood sugar monitoring, blood pressure, specialized blood work, we

as registered staff have to advocate on behalf of the resident and bring this to the attention of the Physician immediately for further clarification".

During an interview with the resident s attending Physician, the Physician indicated that he was not aware that the previous order had been cancelled and that the resident s blood sugars were not being monitored. It had not been brought to his attention until after the resident was hospitalized. The pharmacy servicing the home, indicated in an email to the Supervisor of Care, that when there was an order to change BS monitoring it trumps the previous order and the monitoring aspect needs to be sorted out by the nurse and MD, which was the reason the blood sugar monitoring order was stopped.

In July, 2014, two registered staff involved in resident #100 s care during the time she was taking the newly prescribed medication were disciplined for not complying with their Regional Values, the College of Nurses Professional Standards, and the Residents Bill of Rights which states "Every resident has the right not to be neglected by the licensee or staff"

B) In May, 2014, a PSW reported that resident #101 had a large purplish bruise on their forearm, which was observed while they were providing care. Staff were not able to determine the cause of the bruise and resident #101 was not able to communicate what had occurred due to their health conditions.

Later that same day, the resident was not able to weight-bear when staff transferred the resident to the toilet using the sit to stand lift. Resident #101 s leg was swollen and painful to touch, however, staff did not conduct a pain assessment. The resident did not receive any additional pain medication for this pain, only their regularly scheduled Tylenol. A referral was left for the Physician.

The following day, the resident s leg remained swollen and painful. Resident #101 had difficulty weight bearing and ambulating in a wheelchair. Staff continued to transfer the resident using a sit to stand lift. There was no pain assessment completed or titration of pain medication. Another referral was completed for the Physician to assess as well as the Physiotherapist.

The next morning, the RPN noted the right leg to be bruised and swollen and requested a requisition be completed on the day shift for an x-ray of the resident s leg. That afternoon, staff documented that the resident s leg was swollen and painful

to touch. The Physician was contacted however, no orders were received including titration of pain medication, and the Physician did not go to the home to assess the resident.

The Nurse Practitioner(NP) was contacted and came in to assess the resident. The NP ordered the resident to go to the hospital for an x-ray and documented that the resident had facial grimacing and pain during this assessment. There were no changes in the resident s pain medication.

The resident was sent to hospital and returned to the home with a diagnosis of leg pain. There was no x-ray report sent back to the home, only a report on a doppler that was done. Staff did not follow up with the hospital regarding the resident s x-ray results.

The following afternoon, the Physiotherapist (PT) assessed the resident and documented that the resident had facial expressions of pain and ordered the resident stay in bed until the x-ray report was received. The PT notified the nurse and the Supervisor of Care and requested they follow up on the x-ray results. Later that afternoon, the RPN spoke to the Physician and was informed that the resident sustained a fracture and that he would be in the next day to assess the resident. There were no new orders received, including pain medication.

The Physician came in to assess resident #101 and ordered that the resident be sent to hospital. Two days later, the hospital advised the home that the resident required surgical repair of the fracture. The resident remained in hospital for five days.

The resident had on-going new pain related to a fractured femur. There were no identified pain assessments conducted, no interventions to relieve the resident s pain, including changes or additions to the regularly scheduled Tylenol that the resident was taking for chronic pain. The resident did not receive a pain assessment until the inspector requested that the home conduct one during this inspection.

It was confirmed by the Supervisor of Care and the Director of Care that resident s #100 and #101 had been neglected by the home.

PLEASE NOTE: This evidence of non-compliance related to prevention of abuse, neglect and retaliation were found during inspection #2014_247508_0021 H-000680-14 (508)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 :

May 30, 2015(A3)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A3)
The licensee shall prepare, submit and implement a corrective action plan to include mandatory retraining of all staff on the Resident s Bill of Rights.

This plan is to be submitted to Roseanne Western via email at: roseanne.western@ontario.ca by January 30, 2014.

Grounds / Motifs :

(A3)

1. The licensee did not ensure that the rights of residents, including residents #100 and #101 were fully respected and promoted when residents #100 and #101 were not cared for in a manner consistent with their needs.

A) Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident s Physician discontinued the medication due to low blood sugar levels. The Physician s order for glucose monitoring at this time, directed registered staff to check the resident s blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100 s Physician ordered a new medication which has a commonly known side effect of increasing blood sugar levels. The resident started this medication the following day. On that same day, the Physician s order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician s order to monitor the resident s blood sugar was not reordered.

The resident s care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident s BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident s BS levels, nor did they take any steps to contact the resident s Physician about BS monitoring.

B) In May, 2014, a PSW reported that resident #101 had a large purplish bruise on their forearm, which was observed while they were providing care. Staff were not able to determine the cause of the bruise and resident #101 was not able to communicate what had occurred due to their health conditions.

Later that same day, the resident was not able to weight-bear when staff transferred the resident to the toilet using the sit to stand lift. Resident #101 leg was swollen and painful to touch, however, staff did not conduct a pain assessment. The resident did not receive any additional pain medication for this pain, only their regularly scheduled Tylenol. A referral was left for the Physician.

The following day, the resident s leg remained swollen and painful. Resident #101 had difficulty weight bearing and ambulating in a wheelchair. Staff continued to transfer the resident using a sit to stand lift. There was no pain assessment completed or titration of pain medication. Another referral was completed for the Physician to assess as well as the Physiotherapist.

The next morning, the RPN noted the right leg to be bruised and swollen and requested a requisition be completed on the day shift for an x-ray of the resident s leg. That afternoon, staff documented that the resident s leg was swollen and painful to touch. The Physician was contacted however, no orders were received including titration of pain medication, and the Physician did not go to the home to assess the resident.

The Nurse Practitioner(NP) was contacted and came in to assess the resident later that afternoon. The NP ordered the resident to go to the hospital for an x-ray and documented that the resident had facial grimacing and pain during this assessment. There were no changes in the resident s pain medication.

The resident was sent to hospital and returned to the home with a diagnosis of leg pain. There was no x-ray report sent back to the home, only a report on a doppler that was done. Staff did not follow up with the hospital regarding the resident s x-ray results.

The following afternoon, the Physiotherapist (PT) assessed the resident and documented that the resident had facial expressions of pain and ordered the resident stay in bed until the x-ray report was received. The PT notified the nurse and the Supervisor of Care and requested they follow up on the x-ray results. Later that afternoon, the RPN spoke to the Physician and was informed that the resident sustained a fracture and that he would be in the next day to assess the resident. There were no new orders received, including pain medication.

The Physician came in the following day and ordered that the resident be sent to hospital. Two days later, the hospital advised the home that the resident required surgical repair of the fracture. The resident remained in hospital for five days.

The resident had on-going new pain related to a fracture. There were no identified pain assessments conducted, no interventions to relieve the resident s pain,

including changes or additions to the regularly scheduled Tylenol that the resident was taking for chronic pain. The resident did not receive a pain assessment until the inspector requested that the home conduct one during this inspection.

It was confirmed by the Supervisor of Care and the Director of Care that resident s #100 and #101 had not been cared for in a manner consistent with their needs.

PLEASE NOTE: This evidence of non-compliance related to the resident s right to be cared for in a manner consistent with their needs were found during inspection #2014_247508_0021 H-000680-14 (508)

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

Jan 30, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A2)
The licensee shall prepare, submit and implement a corrective action plan to include the following:

1. review and revise all care plans of residents with Diabetes Mellitus (DM) to include medical directives, signs and symptoms of hypo and hyperglycemia and interventions to manage residents with DM.

2. develop an auditing system to ensure that all residents with DM are being monitored in accordance with their plan of care.

This plan is to be submitted to Roseanne Western via email at: roseanne.western@ontario.ca by March 31, 2015, with the exception of task #1.

Grounds / Motifs :

(A2)
1. Previously issued as a VPC on September 11, October 23, 2012, February 28 2013, January 21, and January 22, 2014.

Resident #100 s written plan of care directed staff to monitor resident for signs and symptoms of hyperglycemia hypoglycemia - tremors, shaking, confusion, headache, irritability, hunger, nausea, vomiting, cool clammy pale skin, diaphoresis, report extreme thirst, frequent urination, abdominal pain, fatigue, blurred vision, dry flushed skin, shallow rapid breathing. Monitor Lab and check blood sugar twice weekly (randomly) and when necessary (PRN). Monitor blood sugar as ordered and PRN. Report any abnormalities to the Physician.

Resident #100 s regularly scheduled medication to maintain their blood sugar (BS) level was discontinued. A week later, the resident was ordered a new medication to treat a skin condition, which has a commonly known side effect of increasing blood sugar levels. The resident started on this medication the following day.

The resident was not monitored as specified in the written plan of care which resulted in the resident becoming unresponsive and hyperglycemic. As a result, the resident was transferred to hospital and treated for hyperglycemia.

It was confirmed by the Supervisor of Care and the Director of Care that it was the expectation that staff provide care to residents as directed in their plan of care. (508)

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

Mar 31, 2015(A2)

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

(A2)
The licensee shall prepare, submit and implement a corrective action plan to include the following:

1. conduct pain assessments, using a clinically appropriate instrument designed for this purpose, of all residents, including resident #101, that are receiving analgesics to ensure their pain medication is effective.

2. develop and implement an auditing system to ensure pain assessments are being conducted in accordance with the Ministry of Health and Long Term Care Act and Regulations.

3. develop and implement a medical directive to provide registered staff the ability to effectively monitor blood glucose levels, as well as the signs and symptoms of hypoglyemia and or hyperglycemia of residents with Diabetes who are taking drugs with known side effects of hypoglycemia and or hyperglycemia.

This plan is to be submitted to Roseanne Western via email at: roseanne.western@ontario.ca by March 31, 2015 with the exception of task #1.

Grounds / Motifs :

(A3)
1. The licensee did not ensure that when residents, including residents #100 and #101, were taking any drug or combination of drugs, that there was monitoring and documentation of the resident s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A) Resident #100 was taking regularly scheduled medication to manage their diabetes. This medication was discontinued due to low blood sugar levels and daily blood sugar level monitoring was implemented for seven days. After the seven days, the order for daily BS monitoring was discontinued and the resident s blood sugar levels were not monitored for ten days.

In order to treat a skin condition, resident #100 started taking a new medication, which has a commonly known side effect of increasing blood sugar levels. Staff failed to monitor the resident for side effects of this medication or monitor the resident for signs and symptoms of hyperglycemia or hypoglycemia. No one took the resident s blood sugar level until the resident was found unresponsive in June, 2014.

B) Resident #101 was taking regularly scheduled analgesics to manage their chronic pain. In May, 2014, the resident sustained a fracture due to an unwitnessed incident. The resident exhibited pain and staff continued to administer the resident s regular analgesics despite it being ineffective. The resident continued to experience pain regularly for four days until transferred to hospital for surgery. Throughout these four days, staff failed to monitor the resident s response or document the effectiveness of the pain medication.

It was confirmed by the Director of Care that resident #100 and resident #101 were not monitored for side effects or effectiveness of their medications.

PLEASE NOTE: This evidence of non-compliance related to the monitoring and documenting of resident s responses and effectiveness of medication were found during inspection #2014_247508_0021 H-000680-14 (508)

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

Mar 31, 2015(A2)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee, who in June, 2014, had reasonable grounds to suspect an incident of improper or incompetent treatment or care of resident #100, which resulted in harm to this resident will immediately report this incident to the Director.

Grounds / Motifs :

(A3)
1. Previously identified as a VPC on September 24, 2012.

When the licensee had reasonable grounds to suspect that improper or incompetent treatment or care of a resident and or neglect by the licensee or staff of resident #100 had occurred or may have occurred, the licensee did not immediately report the suspicion and the information upon which it was based to the Director.

Resident #100 had a diagnosis of type 2 Diabetes Mellitus and was receiving medication twice daily to maintain normal blood sugar levels. In May, 2014, the resident s Physician discontinued the medication due to low blood sugar levels. The Physician s order for glucose monitoring at this time, directed registered staff to check the resident s blood sugar(BS) levels twice weekly and when necessary (PRN). The Physician (MD) changed the order to daily glucose monitoring for seven days.

A week later, resident #100 s Physician ordered a medication, which has a commonly known side effect of increasing blood sugar levels. The resident started the medication the following day. On that same day, the Physician s order for daily BS monitoring ended and registered staff obtained the last BS level under that order. The previous Physician s order to monitor the resident s blood sugar was not reordered.

The resident s care plan, which provided staff direction in providing care to resident #100, directed staff to monitor the resident for signs and symptoms of hyperglycemia and hypoglycemia and to check the resident s BS twice a week and when necessary (PRN). The Director of Care confirmed that the registered staff caring for resident #100 did not check the resident s BS levels, nor did they take any steps to contact the resident s Physician about BS monitoring.

Commonly known signs and symptoms of hyperglycemia include, frequent urination and lethargy. In June, 2014, the resident s daughter reported to staff that she found the resident in a saturated brief. The next day, resident #100 was assessed by the Registered Nurse (RN) due to reports of the resident being "sleepy". The RN took the resident s vital signs, but did not check the resident s blood sugar. The Nurse Practitioner on-call and the Physician on-call were notified, however, they were not the resident s regular NP or Physician and were not familiar with the resident.

The registered staff indicated during an interview that a thorough report had not been given to the NP and the MD on-call including the resident s diagnosis and current list of medications. There were no orders received. The RN indicated that she was

aware the resident had been on BS monitoring, however, did not obtain a BS level during her assessment nor identify the resident s symptoms as hyperglycemia as she was focused on the resident s elevated blood pressure.

Later that night, the registered staff obtained the resident s vital signs but not the resident s blood sugar. She identified that the resident opened her eyes in response to the resident s name but did not respond to her verbally. She had received a report from a PSW that the resident had to be changed earlier that shift due to a saturated brief.

Early the next morning, the registered staff re-assessed the resident s vital signs and indicated that the resident was not responding verbally but responded to tactile stimuli.

A few hours later, the registered staff assessed the resident and identified that she was unresponsive. The registered staff held the resident s medication due to the resident being unresponsive and unable to swallow. The registered staff attempted to obtain a BS level, however, the BS reading indicated "HI". The NP came in to assess the resident and found the resident laying in bed, unresponsive. The resident s blood sugar level could not be obtained after several attempts with different glucometers as the blood sugar levels were too high for the glucometers to register.

The NP and the registered staff consulted the resident s regular Physician and received orders for treatment. The resident s family member was contacted and had requested that resident #100 be treated at the home. Two hours later, there had been no change in the resident s condition and staff were still not able to obtain a blood sugar reading. Resident #100 remained unresponsive and was transferred to hospital. The resident was hospitalized for multiple days.

During the time resident #100 was hospitalized, resident #100 s family member spoke with the Supervisor of Care (SOC) requesting a record of the resident s blood sugar readings prior to the resident being transferred to hospital. The SOC became aware at this time that the resident s blood sugar readings had not been monitored and that the resident had been hospitalized for hyperglycemia. Later that day, the SOC emailed the Director of Care (DOC) to report this occurrence. The DOC forwarded the same email to the Administrator the following morning.

A few days later, resident #100 s family member spoke with the Supervisor of Care and requested a care conference with the Physician present. In June, 2014, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident s family members. During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic. The resident s daughter requested at this time that another Physician take over resident #100 s care.

During an interview with the resident s attending Physician, the Physician indicated that he was not aware that the previous order had been cancelled and that the resident s blood sugars were not being monitored. It had not been brought to his attention until after the resident was hospitalized. The pharmacy servicing the home, indicated in an email to the Supervisor of Care, that when there was an order to change BS monitoring it trumps the previous order and the monitoring aspect needs to be sorted out by the nurse and MD, which was the reason the blood sugar monitoring order was stopped.

The Director of Care sent an email to the registered staff informing them that there had been a very serious incident of a resident started on a new medication and the resident s blood sugar levels had not been monitored, resulting in negative consequences for the resident.
The email also stated that "as part of our nursing competencies we need to be aware of the side effects of the medications that we are administering and advocate for our residents. Should the Physician omit to writing an order for monitoring for those side effects such as blood sugar monitoring, blood pressure, specialized blood work, we as registered staff have to advocate on behalf of the resident and bring this to the attention of the Physician immediately for further clarification".

In June, 2014, the Inspector arrived at the home to follow up on an unrelated Critical Incident and the complaint received from resident #100 s family member regarding this incident. An interview with the Supervisor of Care indicated that she became aware of this incident six days after the resident was transferred to hospital. The DOC and the Administrator both indicated during separate interviews, that they were informed the following day from the email sent from the SOC. The SOC and the DOC also indicated during the interviews that they had accepted responsibility for resident #100 becoming hyperglycemic and hospitalized.

Six days after the care conference, the resident was diagnosed with an infection and was started on medication. The resident s health condition continued to decline and the resident was transferred back to the hospital.

In July, 2014, resident #100 was re-admitted back to the home as the infection had resolved and the resident was deemed palliative. Resident #100 died three days later.
The Social Worker informed the SOC and the Administrator that resident #100 passed away.

In July, 2014, after the resident passed away, two registered staff involved in resident #100 s care during the time she was taking the newly prescribed medication were disciplined for not complying with their Regional Values, the College of Nurses Professional Standards, and the Residents Bill of Rights which states "Every resident has the right not to be neglected by the licensee or staff"

In July, 2014, during a follow up inspection with Inspector #147, the Director of Care and the Supervisor of Care confirmed during an interview that they were aware of the seriousness of the incident. They acknowledged that resident #100 did not receive the care required, and did not report that resident #100 was hospitalized for hyperglycemia to the Director on the date in June, 2014. The Administrator also confirmed during an interview, that when they became aware that the resident was hospitalized due to improper care, it should have been reported to the Director.

There was a complete failure of all staff, including the Supervisor of Care, the Director of Care, and the Administrator, to report to the Director. (508)

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

Dec 05, 2014

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to include the mandatory retraining of all staff on the policy to promote zero tolerance of abuse and neglect of residents.

This plan is to be submitted to Roseanne Western via email at: roseanne.western@ontario.ca by January 30, 2014.

Grounds / Motifs :

1. Previously issued on September 24, 2012, as a VPC

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

In June, 2014, resident #100 was transferred to hospital and admitted for eight days for a diagnosis of hyperglycemia. Documentation in the resident records indicated the resident had been exhibiting symptoms of hyperglycemia for two days prior to transfer to hospital. Resident #100's family member spoke with the Supervisor of Care requesting a record of the resident's blood sugar readings prior to the resident being transferred to hospital. The resident had a diagnosis of type 2 Diabetes Mellitus and had previous Physician orders for the monitoring of blood sugar levels which had been discontinued.

The Supervisor of Care became aware at this time, that the resident's blood sugar

readings had not been monitored and that the resident had been hospitalized for hyperglycemia. Investigation into the cause of the incident was initiated by the Supervisor of Care when it was brought to their attention.

Later that day, the Supervisor of Care sent an email to the Director of Care informing her of this incident, and indicated in this email that the resident's blood sugar had not been monitored. The following day, the Director of Care forwarded this email to the Administrator to inform him of this incident.

A week later, a care conference was held with the Physician, Supervisor of Care, Director of Care, Social Worker, Registered Nurse, Activation Therapist, and the resident's family members. During the care conference, the Physician admitted that there were gaps in the process which resulted in the resident becoming hyperglycemic.

The home's policy #LTC1-05.01, titled, Prevention, Reporting and Elimination of Abuse/Neglect, in the Residents' Care and Services policy manual, defined "Neglect" as the failure to provide a resident with the treatment, care, services or assistance required for their health, safety or well-being of a resident. Neglect included a pattern of inaction that jeopardized the health, safety or well being of one or more residents.

Policy #LTC1-05.01, Prevention, Reporting and Elimination of Abuse/Neglect, directed any person who had first knowledge of abuse or suspected abuse should immediately inform a member of the centre's staff and the Director, Performance Improvement and Compliance Branch, MOHLTC.

In July, 2014, during a follow up inspection with Inspector #147, the Director of Care and the Supervisor of Care confirmed that they were aware of this incident and acknowledged that resident #100 did not receive the care required, but did not report it to the Director as directed in their policy. [s. 20. (1)]

(508)

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

Jan 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 19 day of June 2015 (A3)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : ROSEANNE WESTERN - (A3)

Service Area Office / Bureau régional de services : Hamilton