Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2017;	2017_572627_0010 (A4) (Appeal\Dir#: DR#073)	009414-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

AU CHATEAU
100 MICHAUD STREET STURGEON FALLS ON P2B 2Z4

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

SYLVIE BYRNES (627) - (A4)(Appeal\Dir#: DR#073)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#003
The Director's review was completed on 08/11/2017.
Order(s) CO#003 was altered to reflect the Director's review DR#073.

Issued on this 14 day of November 2017 (A4)(Appeal\Dir#: DR#073)

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

Original report signed by the inspector.

Ontario

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SYLVIE BYRNES (627) - (A4)(Appeal/Dir# DR#073)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 29- June 2, 2017, and June 5-9, 2017.

The following additional intakes were inspected during this Resident Quality Inspection:

- Three Critical Incidents (CIs) the home submitted to the Director regarding alleged staff to resident abuse,

- Three CIs the home submitted to the Director regarding alleged resident to resident abuse,

- Two CIs the home submitted to the Director regarding plan of care,

- One CI the home submitted to the Director regarding an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Service Manager, Human Resources (HR) Manager, Scheduling Coordinator, Infection Prevention and Control program (IPAC) Lead, Skin and Wound/Continence program Lead, Resident Assessment Instrument (RAI) Coordinator, Behavioural Supports Ontario (BSO) staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aids, Housekeeping staff, Maintenance staff, Food Service staff, family members, and residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

10 WN(s)
5 VPC(s)
3 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 :

(A2)
1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, neglect is defined as 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.

Resident #009 was identified as having had an illness from the past to most recent Minimum Data Set (MDS) assessment. Inspector #543 conducted an observation on a specific date and time and noted that the resident was in their chair, awake with a certain intervention in place. During a subsequent observation the following day, the resident was in their bed sleeping, with the intervention in place. Five days later after the initial observation, during an observation, the Inspector noted the resident was not in their room; a review of resident #009's progress notes indicated the resident had passed away.

Inspector #543 reviewed resident #009's most recent care plan for the focus of Activity of Daily Living (ADL) assistance which identified the level of care resident #009 required. Related to risk of falls, the plan of care indicated that resident #009 was at a specific risk for falls related to various disease process.

A)
Inspector #543 conducted a review of resident #009's health care record, which indicated that for a four month period, on several occasions the resident had numerous complaints of feeling unwell, and requested to be transferred to the hospital.

1) It was documented in the resident's progress notes that during the first month,

resident #009 had several health complaints. At this time the resident maintained a certain level of independence with their ADLs. The progress notes indicated that the physician assessed the resident and adjusted their medications, with instructions to monitor.

2) Documentation indicated that resident #009 requested to be sent to the hospital the following month. Throughout this month, resident #009 continued to have a specific symptom. The resident continued to maintain their level of ADLs, however near month end they had a decline in their level of ADLs. They requested to be assessed by the physician on two specific dates during the month.

3) It was documented in the progress notes that in the third month, resident #009 continued with complaints of a specific symptom, pain to a stated area, and often refused meals. Towards the end of the month, resident #009 requested to be sent to the hospital and was not sent. A review of resident #009's progress notes indicated that the resident had not been feeling well, and wanted to be sent to the hospital. RN #136 documented that they were asked by the previous shift RN to assess the resident's physical status. The documentation indicated RN #136's assessment, and that the resident was experiencing specific symptoms and to continue to monitor.

Inspector #543 interviewed RN #136 who stated that they were not aware that the resident had requested to be sent to the hospital. They indicated that they received report from the previous shift RN, who stated they did not have time to complete a physical assessment and asked if RN #136 could complete one. RN #136 stated that the week prior to the assessment they had completed, resident #009 had more reports of specific symptoms and refusing meals. Upon their assessment they identified a specific symptom, and referred to the physician. RN #136 verified that this resident was cognitive, and was able to make decisions such as requesting to be sent to the hospital. They added, that had they been aware that the resident had requested to be sent to the hospital they would have done so.

4) Documentation in the progress notes outlined that towards the end of the month the resident was in a specific area of the home and that their health condition had deteriorated. The documentation also indicated that the resident was experiencing more severe symptoms and had a significant decline in their ADLs.

5) The progress notes indicated that during the following month, resident #009's symptoms were worsening, they now required extensive assistance with all of their

ADLs, and continued to refuse meals. Documentation indicated that on a specific date during the month, the resident was in a specific area of the home, completing a certain activity and was experiencing severe symptoms, and were returned to their room. Resident #009 stated they were afraid to be alone and requested to be sent to the hospital at that time and was not sent.

B)
On a specific date during the fourth month, documentation indicated that the resident had sustained an incident. The physician in the home at the time assessed the resident and consulted the resident's regular physician who advised not to send resident #009 to hospital until they were in to assess the resident.

Inspector #543 reviewed the physician's documentation, who assessed the resident after they sustained the incident, and described that "they had no apparent loss of conscious, no call for help, was found on the floor". This documentation also identified that the resident was not assessed for three checks during the night because the resident was asleep.

Upon review of the home's "Vital signs monitoring" (H-040), the policy indicated that all residents with a possible head injury will be submitted to Head Injury Routine (HIR) observation. This policy outlined that vital signs, pain scale, pupil size and level of consciousness were to be recorded for forty eight hours (every fifteen minutes for the first hour until stable, every half hour for the next three hours or until stable, every hour for the next eight hours or until stable, every four hours for the next 12 hours and every eight hours for the 24 hours).

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10., 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 has failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with. See WN #3 for details.

Inspector #543 reviewed this resident's HIR-"Neuro Watch" which verified that this resident was not assessed on three separate occasions during the required 48 hours period post incident. The Inspector reviewed resident #009's Neuro-Watch for a specific date which identified that vital signs were initiated at a certain time. The document indicated that three checks at specific times for resident #009 were not assessed as per the "Vital signs monitoring", indicating the resident was sleeping. This document also indicated that for two later assessments were not

completed.

Inspector #543 interviewed RPN #134 who stated they discovered resident #009 on the floor in their room. At that time they called for the Registered Nurse (RN) to come and assess the resident. They stated the resident's vital signs were "ok" at that time and instructed the Personal Support Worker (PSW) to continue with required assessments. The PSW informed them that the resident's vital signs were stable during two assessments, at which point they instructed the PSW not to wake the resident up for further vitals, but to ensure the vitals at a later time were completed before they finished their shift.

Inspector #543 interviewed RN #126, who attended to the resident the day of the incident. They stated that the process of sending residents to the hospital when they request essentially depends on the situation. They would discuss with the resident's family, but if the resident could be treated at the home, they would do that as to avoid an emergency room visit. When the Inspector questioned why resident #009 was not sent to hospital at their request, they stated what likely happened was that staff spoke with the physician and decided not to send the resident. The Inspector noted concerns with the HIR and that some of the resident's vital signs were not completed. RN #126 verified that it was "absolutely unacceptable" that the vital signs were not completed for three consecutive checks. They added that a RN must approve a vital sign not being completed, and that the resident's vital signs must be stable.

Inspector #543 interviewed RN #133, about the home's process of transferring residents to the hospital if requested. They stated that they would call the physician on call first, who would decide whether or not to send the resident to hospital. However, if the resident wished to be sent, then they have no choice but to send the resident.

Inspector #543 reviewed additional documentation received from the Licensee: An Admission note from a hospital facility dated on a specific date, indicated that resident #009 was admitted due to specifics symptoms and medical conditions. The note identified that the resident had a specific advanced directive for emergency care, and further discussion related to the type of care required would ensue. This note indicated that resident #009's medical condition had progressed since their last assessment, and as a result they were not a candidate for the procedure. The plan identified in the note, was that of a family member speaking of a specific approach, and that discussions would be had with the resident and their

spouse.

Another admission note from the same facility indicated resident #009 had been admitted for specific care as well as a respite bed and then acute care. The note indicated that the resident had been returned to Au Chateau for rest and possible permanent admission. The note identified that resident #009 was at the other facility for specific care and comfort to control their medical condition.

On a specific date, Inspector #543 spoke with the physician, who stated that the resident had a specific diagnosis. They indicated that the resident and their family was aware of the prognosis. They verified that the resident had apparently had an incident on a specific date. They stated that they had notified the coroner. Inspector #543 reviewed the Medical Death Certificate that identified that resident #009's immediate cause of death was due to their medical condition's deterioration.

Inspector #543 interviewed the Director of Care (DOC). During this interview, they stated that resident #009 was capable of making their own decisions. The DOC verified that it was Au Chateau's policy that a resident can decide to go to the hospital on their own, and they would allow it. They substantiated that resident #009 was not sent to the hospital as requested. They indicated that this was because the physician and the SDM had not wanted resident #009 sent. The DOC agreed that this resident should have been sent to the hospital. They further stated that resident #009 was not given specific care. The DOC agreed that resident #009 was not provided the right to make their own decision about the care they received.

Additionally, the home failed to protect resident #009 from neglect as evidenced by noncompliance identified in WN #3, where the home failed to ensure that the home's policies titled "Fall Prevention and Management Program", last revised February 14, 2017, and "Vital Signs Monitoring" (H-040), last revised May 2015, were complied with. [s. 19. (1)]

Additional Required Actions:

(A3)(Appeal/Dir# DR# 073)
The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A Critical Incident (CI) report was submitted to the Director regarding an unexpected death. A review of the CI investigation notes by Inspector #627, revealed that at the time of the incident, the only scheduled and working registered nurse (RN) in the home was RN #125, who was an agency staff member employed through the Plan A agency.

During a telephone interview with Inspector #627, RN #125 stated they had worked as the only RN in the home during a particular shift, on a specific date. They stated that they were employed in a specific agency and picked up the shift as an agency staff member. RN #125 stated that they also worked another specific shift on another date, at the home, as the only RN on site.

During an interview with the Inspector, the DOC stated that the home had one RN on duty during the evening shift, night shift and during every weekend and holiday shifts. They stated that the master schedule for the registered nursing staff was

completed for a six week period. When the schedule was completed with all available staff, it was posted on the Ontario Nursing Association (ONA) board in the nursing room, which identifying the shifts that the home was unable to fill due to lack of available employed staff. The staff RNs were given the opportunity to request to pick up any of the remaining vacant shifts. Up to six weeks prior to the scheduled shift, the home posted the schedule identifying the shifts that remained uncovered to the specific agency web site.

The DOC reviewed the master schedule with the Inspector for three specific time periods, and identified that a total of eight shifts had been covered by a specific agency RN. The night shifts for five specific dates remained unfilled and posted in the home's ONA board in the nursing room as well as on the specific agency's website. (Agency RNs were able to fill the remaining available shifts as the only RN working in the home).

During an interview with the Inspector, the Scheduling Coordinator reviewed the previous master schedules for RNs, and identified that six shifts in March, 2017, nine shifts in April, 2017, eight shifts in May, 2017, and three shifts from June 1 to 3, 2017, were covered by an RN from a specific agency as the only RN on duty in the home.

A review by the Inspector of the policy titled "Staffing Plan and Nursing Staff Shortage Plan" identified the contingency staffing plan as: If there is no staff available, agency staff will be requested. If the agency staff was replacing an RN on evening, night and weekends, a member of the regular home staff will be assigned "stand by" to assist new RN in trouble shouting.

During an interview with Inspector #627, the DOC confirmed that they utilized the specific agency to fill RN shifts gaps in their schedule for emergencies, and to fill vacancies in the master schedule because of a lack of staffing. [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #009 was identified as having had an illness from the past to most recent Minimum Data Set (MDS) assessment. Inspector #543 reviewed resident #009's health care record, which identified that this resident had an unwitnessed fall on a specific date and passed away the same day.

Inspector #543 reviewed the policy titled "Falls Prevention and Management Program" and their home policy titled "Vital Signs Monitoring" (H-040). These policies indicated that all residents with a head injury due to a fall or signs of a possible head injury would be required to have the Head Injury Routine (HIR) observation completed. The policy outlined that vital signs, pain scale, pupil size and level of consciousness were to be recorded for 48 hours (every 15 minutes for the first hour until stable, every half hour for the next three hours or until stable, every hour for the next eight hours or until stable, every four hours for the next 12

hours and every eight hours for the 24 hours). The Vital Signs Monitoring policy also indicated that a PSW would take vitals signs assigned thereafter unless otherwise told by the RN: blood pressure, pulse, respiration, temperature, oxygen saturation, pain scale, Glascow Coma Scale, pupil reaction and level of consciousness documented and immediately reported each findings to the RPN/RN.

Inspector #543 reviewed resident #009's HIR form which indicated "sleep" as the only documented entry, on three separate occasions. Two later entries had not included pupil reaction. Furthermore, there was no documentation on the HIR-Neuro-Watch form to indicate that the resident's level of consciousness (LOC) was assessed during the nine hours prior to the resident's passing. A progress note indicated that the resident was found to be unresponsive to verbal and pain stimuli at a later time. The resident passed away shortly after.

Inspector #543 interviewed RPN #134 who stated that they discovered resident #009 on the floor. At that time they called for the RN to come and assess the resident. They stated the resident's vital signs were "ok" at that time and instructed the PSW to do the neuro watch. On two later occasions, the PSW informed them that the resident was sleeping and that their vital signs were stable, at which point they instructed the PSW not to wake the resident up for further vitals, but to ensure the vitals at an early morning time were completed before they finished their shift.

Inspector #543 interviewed RN #135 who verified that they completed the post fall assessment. They stated they were called by the RPN when the resident fell, and stated they received the resident on the floor. At that time they indicated that neuro vitals were initiated and care was provided as per the home's Falls policy.

Inspector #543 interviewed RN #126, who attended to the resident. The Inspector identified that they noted concerns with the HIR documentation and that some of the resident's vital signs were not completed. RN #126 verified that it was "absolutely unacceptable" that the vital signs were not completed for three consecutive checks and that the resident's LOC was not assessed. They added that a RN must approve a vital sign not being completed, and that the resident's vital signs must be stable. [s. 8. (1) (b)]

2. During record reviews, Inspectors #642, #543 and #627 noted that the heights of many residents were not taken yearly. Residents #002, 014, 007, 023, 006, 024, 025, 026, 027 and 029's last recorded height was in 2015. Residents #029 and

#020 last recorded height was in January 2016.

A review of the policy titled "Weight and Height Taking and Recording" indicated that each resident's height was taken on admission and annually thereafter by the RPN or delegate preparing the physical examination chart.

During an interview with Inspector #627, PSW #127 stated that a resident's height was measured on admission and annually. The staff received a list from the RN, of residents who needed their heights taken, and this was be completed at that time.

During an interview with the Inspector, the DOC stated that they had realized that the heights were not taken yearly and that they were working on it. The DOC confirmed that the home's expectation was for resident's to have their height measured yearly and that the home's policy titled "Weight and Height Taking and Recording" had not been followed. [s. 8. (1) (b)]

Additional Required Actions:

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

(A4)(Appeal/Dir# DR#073)
The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident (CI) report was submitted to the Director. The CI report alleged that two staff members had failed to reapply a specific intervention after providing care to resident #001, which had caused the resident to fall.

During an interview with the Inspector #627, resident #001's family member stated that months prior, the resident had sustained a fall with injury when the staff had not applied the specific intervention when the resident was completing a certain activity. They further stated that the resident needed the intervention when completing another certain activity to prevent them from falling.

A review by Inspector #627 of the care plan in effect at the time of the incident for resident #001 indicated an intervention for a personal assistance services device (PASD) to assist with ADLs.

A review by the Inspector of resident #001's progress notes revealed an entry documented by RN #139, stating that the specific intervention which was listed as a PASD was to be changed to a restraint as the main goal of the specific intervention was now to prevent falls, therefore it was considered a restraint.

During a telephone interview with PSW #120, they stated that the resident needed the specific intervention to prevent them from falling.

During an interview with the Inspector, the DOC stated that the specific intervention had been used as a PASD for ADLs however, it was now used to prevent the resident from falling. The DOC confirmed that the care plan should have been reviewed and revised to reflect the resident's changes in their care needs. They further demonstrated to the Inspector that the plan of care had been updated two days after the incident and the specific intervention was now used as a restraint to ensure the resident's safety. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001 is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was reported immediately to the Director.

A critical incident (CI) report was submitted to the Director alleging resident to resident abuse between resident #012 and resident #010. Resident #010 sustained an injury.

A review of the CI report by Inspector #543 indicated that the incident occurred on a specific date and time and was reported to the Director more than 26 hours after the incident.

A review of the policy titled "Zero Tolerance of Abuse and Neglect" indicated that "all staff, volunteers, contractors and affiliated personnel were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long Term Care (MOHLTC)".

Inspector #627 interviewed RN #126 who stated that it was the home's expectation that any allegations of resident to resident abuse which caused an injury were reported immediately. After business hours and on weekends, the RN was to call the after hour line. They stated that the staff member was new and had not known to call, therefore, RN #126 had called the following day.

During an interview with Inspector #627, the DOC stated that it was the home's policy that the RN on duty would call the after hour line immediately for any allegations of resident to resident abuse which caused an injury. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was reported immediately to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence management program provided for assessment and reassessment instruments.

According to O.Reg 79/10 s. 51 (2) (a), each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, types,of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using an clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #005 was identified as having incontinence from their past most recent Minimum Data Set (MDS) assessment.

Inspector #627 reviewed the home's policy titled "Continence Management Program" which identified that a resident's continence status was assessed upon admission, quarterly and whenever there was a change in health status that affected bowel or bladder function. Upon admission, the resident's voiding and bowel patterns was assessed using the Resident Assessment Instrument - Minimum Data Set (RAI-MDS), "Continence Assessment Form" and the "Bladder Monitoring Tool". The RAI-MDS assessment was used as the quarterly assessment tool and whenever there was a change in the resident's health status that affected bowel or bladder function.

During an interview with the Inspector, RPN #132, who was the care plan RPN, stated that the RN or RAI Coordinator would make them aware of any change in a resident's continence status. RPN #132 stated that they would review the RAI-MDS, flow charts related to the resident's continence history and the "Bladder Monitoring Tool" (if it had been completed).

During an interview with Inspector #627, RN #114, (Continence Program Lead), stated that when a resident experienced a change in their continence status, the RAI-MDS, and the "Bladder Monitoring Tool" were used to assess the resident's continence status and that it may not include pattern of incontinence, the causal factors, the type of incontinence or the potential to restore function with specific interventions. [s. 48. (2) (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 any resident identified with a change in continence status will be reassessed with a clinically appropriate assessment tool which identifies causal factors, the type of incontinence or the potential to restore function with specific interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Resident #005 was identified as being incontinent from the past to most recent Minimum Data Set (MDS) assessment.

Inspector #627 reviewed resident #005's most recent Resident Assessment Instrument - Minimum Data Set (RAI-MDS) which indicated that the resident tended to be incontinent daily, but had some control present.

During an interview with the Inspector, resident #005 stated that they were no longer toileted due to physical limitations. Prior to this change, they had been able to toilet using a specific type of equipment. They stated that when they felt the urge to void, they voided right away. The staff had not had time to toilet them prior to being incontinent.

The Inspector reviewed the "Continence Management Program" which identified that residents who required assistance to use the toilet must receive the appropriate level of assistance from staff.

The Inspector reviewed the care plan in effect at the time of the inspection and identified under the focus of activities of daily living (ADL) and toileting that the resident required total assistance from one staff.

During an interview with the Inspector, PSW #113 stated that resident #005 was totally incontinent of urine. The resident was checked regularly for incontinence and changed as required.

During an interview with the Inspector, RN #114, who was the lead for the Continence Program, and the RAI Coordinator, stated that resident #005 had a change of status on a specific date. They had physical limitations and required increased assistance from staff. They further stated that resident #005 should have been provided with assistance to maintain their continence level. The RAI Coordinator stated that staff may have stopped toileting them as it was more convenient for them. [s. 51. (2) (d)]

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 resident #005 will receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home, any changes and improvements identified in the review were implemented and a written record was kept of everything.

Inspector #627 completed a review of three of the home's documented medication incidents.

During an interview with the Inspector, the DOC stated that quarterly meetings were held with the Pharmaceutical and Therapeutic Committee (PTC), the Physician, Pharmacist, guests, RNs and RPNs.

A review by the Inspector of the minutes of the last PTC meeting for a specific date failed to reveal a review of the medication incidents and adverse drug reactions which had occurred in the home.

During an interview with the Inspector, the DOC stated that quarterly meetings were held with the PTC, the Physician, Pharmacist, guests, RNs and RPNs. The use of antipsychotic medications in the home was reviewed, as well as other medication issues identified in the home. Medication incidents and adverse drug reactions were reviewed at the time they occurred and corrective actions were taken right away. The DOC confirmed that there was no quarterly review of medication errors and adverse drug reactions that had occurred in the home. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reaction, to be implemented voluntarily.

WN #9: 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 has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director which alleged staff to resident verbal abuse towards resident #018 from Dietary Aid #118.

Inspector #642 reviewed resident #018's progress notes which identified that on a specific date RPN #138 charted that the resident was upset after describing a verbally crude comment that Dietary Aid #118 had stated.

The home's policy titled "Zero Tolerance of Abuse and Neglect" indicated that "Verbal Abuse, means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident" and the policy was to be complied with.

During an interview with Inspector #642, Dietary Aid #117 stated that they had witnessed the incident of alleged abuse between Dietary Aid #118 and resident #018, and that Dietary Aid #118 had voiced a verbally crude comment and that the resident was upset.

During an interview with the Inspector, Dietary Aid #118 admitted to saying the verbally crude comment to resident #018. The further stated that they had received disciplinary action from the Human Resource Manager.

During an interview with Inspector #642, the DOC indicated that it was the expectation of the home that all staff followed the policy titled "Zero Tolerance of Abuse Policy", last revised September 1, 2016, and that Dietary Aid #118 had not complied with the policy.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine were supported and individualized to promote comfort, rest and sleep.

During an interview with Inspector #543, resident #014's family member indicated that resident #014 was being left after meals and would fall asleep while sitting. They indicated that staff would only put the resident to bed once in a while.

Inspector #543, reviewed this resident's most recent care plan which indicated that the resident was to be transferred to bed 30 minutes after their meals.

On three separate occasions, Inspector #543 observed resident #014 in their bedroom, sleeping in their chair.

During interviews with the Inspector, PSW #130 and #103 stated that care was provided to the residents according to the resident's care plan. They indicated that resident #014's care plan identified that the resident was to be put to bed after meals.

During an interview with the Inspector, RN #133 indicated that the care plans were provided and updated to identify the resident's current care needs. They verified that staff were to provide the care as indicated in the care plan.

During an interview with the Inspector, the DOC stated that the care plans were in place to guide the care provided to residents. They stated that resident #014 was not to be left in their chair to sleep after meals and that the resident's desired bedtime and rest routine had not been supported. [s. 41.]

Issued on this 14 day of November 2017 (A4)(Appeal/Dir# DR#073)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SYLVIE BYRNES (627) - (A4)(Appeal/Dir# DR#073)

Inspection No. / No de l'inspection : 2017_572627_0010 (A4)(Appeal/Dir# DR#073)

Appeal/Dir# / Appel/Dir#: DR#073 (A4)

Log No. / No de registre : 009414-17 (A4)(Appeal/Dir# DR#073)

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

Report Date(s) / Date(s) du Rapport : Nov 14, 2017;(A4)(Appeal/Dir# DR#073)

Licensee / Titulaire de permis : THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4

LTC Home / Foyer de SLD : AU CHATEAU
100 MICHAUD STREET, STURGEON FALLS, ON, P2B-2Z4

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jacques Dupuis

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To THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A3)(Appeal/Dir# DR# 073)
The following Order has been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes
Nursing Inspector, Long-Term Care Inspection Branch, 159 Cedar Street, Suite
403, Sudbury, Ontario, P3E 6A5, or faxed to the inspector's attention, at (705) 564-3133, or email SudburySAO.moh@ontario.ca. This plan must be submitted by August 18, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A Critical Incident (CI) report was submitted to the Director regarding an unexpected death. A review of the CI investigation notes by Inspector #627, revealed that at the time of the incident, the only scheduled and working registered nurse (RN) in the home was RN #125, who was an agency staff member employed through the Plan A agency.

During a telephone interview with Inspector #627, RN #125 stated they had worked as the only RN in the home during a particular shift, on a specific date. They stated that they were employed in a specific agency and picked up the shift as an agency staff member. RN #125 stated that they also worked another specific shift on another date, at the home, as the only RN on site.

During an interview with the Inspector, the DOC stated that the home had one RN on duty during the evening shift, night shift and during every weekend and holiday shifts. They stated that the master schedule for the registered nursing staff was completed for a six week period. When the schedule was completed with all available staff, it was posted on the Ontario Nursing Association (ONA) board in the nursing room, which identifying the shifts that the home was unable to fill due to lack of available employed staff. The staff RNs were given the opportunity to request to pick up any of

the remaining vacant shifts. Up to six weeks prior to the scheduled shift, the home posted the schedule identifying the shifts that remained uncovered to the specific agency web site.

The DOC reviewed the master schedule with the Inspector for three specific time periods, and identified that a total of eight shifts had been covered by a specific agency RN. The night shifts for five specific dates remained unfilled and posted in the home's ONA board in the nursing room as well as on the specific agency's website. (Agency RNs were able to fill the remaining available shifts as the only RN working in the home).

During an interview with the Inspector, the Scheduling Coordinator reviewed the previous master schedules for RNs, and identified that six shifts in March, 2017, nine shifts in April, 2017, eight shifts in May, 2017, and three shifts from June 1 to 3, 2017, were covered by an RN from a specific agency as the only RN on duty in the home.

A review by the Inspector of the policy titled "Staffing Plan and Nursing Staff Shortage Plan" identified the contingency staffing plan as: If there is no staff available, agency staff will be requested. If the agency staff was replacing an RN on evening, night and weekends, a member of the regular home staff will be assigned "stand by" to assist new RN in trouble shouting.

During an interview with Inspector #627, the DOC confirmed that they utilized the specific agency to fill RN shifts gaps in their schedule for emergencies, and to fill vacancies in the master schedule because of a lack of staffing. [s. 8. (3)]

The decision to issue this compliance order was based on the scope which was identified as a pattern, the severity which indicated a potential for actual harm and the compliance history indicated one or more unrelated non compliance in the last three years. (627)

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

Nov 10, 2017

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's policies titled "Falls Prevention and Management Program", last revised February 14, 2017, and "Vital signs monitoring" (H-040), last revised May 2015" are complied with.

Grounds / Motifs :

(A4)(Appeal/Dir# DR#073)
1. The licensee has failed to ensure that 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 has failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Resident #009 was identified as having had an illness from the past to most recent Minimum Data Set (MDS) assessment. Inspector #543 reviewed resident #009's health care record, which identified that this resident had an unwitnessed fall on a specific date and passed away the same day.

Inspector #543 reviewed the policy titled "Falls Prevention and Management Program", and their home policy titled "Vital Signs Monitoring"(H-040). These policies indicated that all residents with a head injury due to a fall or signs of a possible head injury would be required to have the Head Injury Routine (HIR) observation completed. The policy outlined that vital signs, pain scale, pupil size and level of consciousness were to be recorded for 48 hours (every 15 minutes for the first hour until stable, every half hour for the next three hours or until stable, every hour for the next eight hours or until stable, every four hours for the next 12 hours and every eight hours for the 24 hours). The Vital Signs Monitoring policy also indicated that a PSW would take vitals signs assigned thereafter unless otherwise told by the RN: blood pressure, pulse, respiration, temperature, oxygen saturation, pain scale, Glascow Coma Scale, pupil reaction and level of consciousness documented and immediately reported each findings to the RPN/RN.

Inspector #543 reviewed resident #009's HIR form which indicated "sleep" as the only documented entry on three separate occasions. Two later entries had not included pupil reaction. Furthermore, there was no documentation on the HIR-Neuro-Watch form to indicate that the resident's level of consciousness (LOC) was assessed during the nine hours prior to the resident's passing. A progress note indicated that the resident was found to be unresponsive to verbal and pain stimuli at a later time. The resident passed away shortly after.

Inspector #543 interviewed RPN #134 who stated that they discovered resident #009 on the floor. They stated that the resident's vital signs were "ok" at that time and instructed the PSW to do the neuro watch. On two later occasions, the PSW informed them that the resident was sleeping and that their vital signs were stable, at which point they instructed the PSW not to wake the resident up for further vitals, but to ensure the vitals at an early morning time were completed before they finished their shift.

Inspector #543 interviewed RN #135 who verified that they completed the post fall assessment. They stated they were called by the RPN when the resident fell, and stated they received the resident on the floor. At that time they indicated that neuro vitals were initiated and care was provided as per the home's Falls policy.

Inspector #543 interviewed RN #126, who attended to the resident. The Inspector identified that they noted concerns with the HIR documentation and that some of the

resident's vital signs were not completed. RN #126 verified that it was "absolutely unacceptable" that the vital signs were not completed for three consecutive checks and that the resident's LOC was not assessed. They added that a RN must approve a vital sign not being completed, and that the resident's vital signs must be stable.

The decision to issue this order was based on the scope of this issue which was determined to have been isolated, the severity was determined to be potential for actual harm. The home has a compliance history indicating one or more non compliance in the last three years; VPC in 2016.

(543)

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

Aug 22, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 14 day of November 2017 (A4)(Appeal/Dir# DR#073)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SYLVIE BYRNES - (A4)(Appeal/Dir# DR#073)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Service Area Office / Bureau régional de services : Sudbury