Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 24, 2015	2015_355588_0024	024280-15	Resident Quality Inspection

Licensee/Titulaire de permis

MACGOWAN NURSING HOMES LTD
719 Josephine Street P.O. Box 1060 WINGHAM ON N0G 2W0

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

BRAEMAR RETIREMENT CENTRE
719 Josephine Street North, R.R. #1 P.O. Box 1060 WINGHAM ON N0G 2W0

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

CHRISTINE MCCARTHY (588), REBECCA DEWITTE (521), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2015.

This inspection was conducted concurrently with Complaint Inspection Log #'s 018714-15 IL#39606-LO related to falls, 023264-15 IL#40241-LO related to housekeeping and bathing, 025356-15 IL#40320-LO related to staff shortages, and 025721-15 related to bathing, staff shortages and bed entrapment.

During the course of the inspection, the inspector(s) spoke with 40 residents, the Administrator, the Director of Care, three Registered Nurses, seven Registered Practical Nurses, five Personal Support Workers, one Nursing Aide, one Health Care Aide, the Food Services Supervisor, the Maintenance Manager, the Fire Prevention Officer, the Pharmacist, the Long Term Care Home Physician, the Resident Council Secretary, the Activities Manager, the Ward Clerk, one Dietary Aide, and two Housekeepers.

During the course of the inspection, the inspector(s)conducted a tour of all Resident Home areas, common areas, dining rooms, medication room, medication storage areas, observed resident care provision, resident-staff interactions, dining service, recreational activities, medication administration, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **16 VPC(s)**
- **1 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.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, under O.Reg 79/10, s.15(2) on August 29, 2014, Inspection #2014_259520_0026.

Observations of all three wings including resident rooms, bathrooms and hallways from September 14 to 23, 2015, by Inspectors #213, #512 and #588 revealed multiple areas of disrepair. Areas of disrepair included scrapes, scuffs, cracks, holes and gouges in walls, doors, door frames, floors and baseboards.

The Administrator and a Maintenance Staff member confirmed in an interview on September 22, 2015, with Inspector #213 that there were multiple areas of disrepair including scrapes, scuffs, cracks, holes and gouges in walls, doors, door frames, floors and baseboards throughout the entire home and that there was no plan in place to remedy these issues. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.
Observations during the Initial tour on September 14, 2015, at 1100 hours revealed a maintenance cart containing a utility knife, a power drill, a pair of scissors, various screw drivers and other tools were left unattended in the lounge dining room while four residents were present.

The Maintenance Manager arrived and confirmed the maintenance cart was left in the lounge unattended and it was the home's expectation that the maintenance cart should always be locked away when it is not supervised. [s. 5.]

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 home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Record review revealed a Quarterly Fall Risk Assessment indicated resident #012 was a moderate risk for falls.

Record review of the Care Plan detail under "Risk for Falls" indicated the frequency of monitoring.

Observation of resident #012 on identified dates in September 2015 revealed this resident to be independently moving about the home while utilizing an aid.

Interview with a registered staff revealed this residents' movement capacity and the monitoring schedule on the Care Plan detail referred to the residents movement and had been mistakenly placed in the "Falls" comment. The staff member stated that it should not be in the "Falls" detail of the Care Plan and that the staff do not check this resident at the determined schedule. [s. 6. (1) (c)]

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

In an interview with Inspector #213, resident #046 stated that they are woken in the morning at a time that they would prefer not to be. Record review of the plan of care for resident #046 revealed nothing related to resident preferences for wake time.

In an interview with Inspector #512 resident #054 stated their preference for the time that they would like to have a bath. Record review of the plan of care for resident #054 revealed nothing related to resident preferences for bathing time. Record review of Point of Care documentation revealed resident #054 received a bath at times that they would prefer not to have one.

Staff interview with two registered staff members, revealed the home did not ask residents' preferences for bathing times or methods, or preferences for wake times or sleep times. [s. 6. (2)]

3. The licensee failed to ensure that the outcomes of the care set out in the plan of care were documented.

Observations of resident #021's room, revealed a beverage on the bed side table. The resident was listed with a cognitive performance scale (CPS) of six.

The unaltered beverage was observed on the bedside table multiple times throughout that day.

During the mealtime, the beverage remained on the residents' bed side table and the resident was taken to the dining room for their meal.

Record review revealed documentation for resident #021's fluid intake was recorded at 50mls and "not applicable" was checked off.

Observations of resident #022's room, revealed a cup containing a liquid, covered with a cling wrap labeled with resident #022's name. The cup was placed on the bed side table with a sealed straw. The resident was listed with a cognitive performance scale (CPS) of four.

The covered cup was observed at multiple times throughout that day.

During the mealtime, the cup remained covered and the resident was taken to the dining room for their meal.

Record review revealed resident #022's fluid intake was documented as a refusal by the staff member who verified the resident had not refused or been given the morning fluids.

An interview with a registered staff confirmed that the documentation was incorrect and that it was the home's expectation that the outcomes of the care set out in the plan of care were documented correctly. [s. 6. (9) 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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Observation on multiple occasions during the month of September, 2015, revealed resident #011 had a specific fall intervention in place.

Record review of Point Click Care, progress notes revealed multiple “Falls note” over a three month period.

Record review of the hard copy file at the Nursing Station revealed "Post Falls Investigations" over the same three month period.

Record review on Point Click Care revealed a “Post Falls Assessment” was not completed on two identified dates during the three month time frame.

Record review of the home's Falls Policy dated September 2010, Policy : F-1 " A Fall Risk Assessment Form is completed on admission, quarterly and post fall to identify the level of risk for the resident."

Interview with a registered staff revealed that the Falls Risk Assessment had not been completed for each fall as indicated on the Post Fall Investigation notes, and that it was the expectation of the home to complete the Falls Risk Assessment after each fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or the Regulation requires the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system; that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

Review of the home’s policy manual revealed that there was no policy regarding whistle-blowing protection or any of the protections afforded under section 26.

In an interview with Inspector #213, the Administrator confirmed that he was not able to locate or produce a policy related to whistle-blowing protection or any of the protections afforded under section 26. He also confirmed that the staff, residents and families have not been advised of or received training related to whistle-blowing protection. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents has a screen and cannot be opened more than 15 centimetres.

Observations made in the yellow Sunroom, which is used by residents and families, revealed three out of four windows opened more than 15 centimetres.

An interview with the Administrator confirmed that the windows opened more than 15 centimetres and that it was the expectation that every window accessible to residents should not open more than 15 centimetres. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or registered nurse in the extended class.

An observation made during the inspection, revealed a type and number of side rails in use when the resident was not in bed.

A staff interview revealed the resident used an identified type and number of side rails for safety.

A review of the plan of care for resident #045 revealed, the type, number, reason, documentation and monitoring requirements for the use of side rails.

Record review of the health care record on Point Click Care and the paper chart for resident #045 revealed no physician's order for a type and number of side rails.

In an interview with Inspector #213, a registered staff member confirmed that there was no physician's order for the type and number of side rails for resident #045 and that it was the expectation of the home to have a physician's order for all restraints. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care included the consent of the resident or if the resident was incapable, by the substitute decision maker.

An observation revealed a type and number of side rail was observed in use when the resident was not in bed.

A staff interview revealed the resident used a type and number of side rails for safety.

A review of the plan of care for resident #045 revealed the type, number, reason, documentation and monitoring requirements for the use of side rails.

Record review of the health care record on Point Click Care and the paper chart for resident #045 revealed no consent from the resident or the resident's substitute decision maker for the type and number of side rails.

In an interview with Inspector #213 a registered staff member confirmed that there was no consent for the type and number of side rails for resident #045 and that it was the expectation of the home to have consent for all restraints. [s. 31. (2) 5.]

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 restraint plan of care includes an order by the physician or registered nurse in the extended class and been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Record review of resident #026's current Care Plan revealed the type, number, when and why to use the side rails.

Observation of this resident's room revealed an identified number and type of rail.

Interview with a registered staff revealed that resident #026, did not have a consent on the hard copy file for the use of the number and type of side rails which were currently in use, on the Admission Consent form-Consent for Treatment. The staff member revealed that there were no other areas that consents were kept other than on the hard copy file.

Record review of resident #021's current Care Plan revealed, the type, number, when and why to use the side rails.

Observation of this resident's room revealed an identified number and type of rail.

Interview with a registered staff revealed that resident #021 did not have a consent on the hard copy file for the use of the number and type of side rail which were currently in use, on the Admission Consent form-Consent for Treatment.

The staff member confirmed that anyone who had been admitted prior to 2011 would not have a Consent for treatment on the Admission Consent form and that every resident admitted after that date had the Consent on file. This registered staff revealed that the expectation of the home was to have up to date Consents on file for Personal Assistance Services Devices (PASD) for each resident residing in the home. [s. 33. (4) 4.]

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 use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was given within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review of Residents' Council meeting minutes dated January 6, February 3, March 3, April 7, May 5, June 2, and July 7, 2015, revealed residents' had voiced concerns without receiving a written response from the licensee.

An interview with the Administrator confirmed a written response was not given to the Residents' Council for concerns brought forward during meetings in January, February, March, April, May, June and July 2015, and it was the homes expectation that a written response was given within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (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 written response is given within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee, Administrator and staff attended Family Council meetings only when invited.

Interview with a Personal Support Worker (PSW) revealed that there was a Family Council, which held meetings approximately every six months. The PSW revealed that "management runs the Agenda" and that they had never attended because they had never been asked to do so.

Record review of the Family Meetings binder which contained minutes dating from 2006 to 2015, revealed that in each of the minutes, the Administrator and staff members were listed as attending, followed by the Administrator's welcome.

An interview with the Administrator revealed that he would like the Council to run quarterly and that he viewed himself as a member of the group. After reviewing the LTCHA 2007, c.8, s. 59 (6) 4. with the Administrator, he confirmed that he "ran the meetings and had not been invited". [s. 64.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee, Administrator and staff attend Family Council meetings only when invited, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee consulted regularly with the Residents' Council, and in any case, at least every three months.

An interview with the Administrator revealed the licensee does not consult regularly, at least every three months, with the Residents' Council. [s. 67.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee consult regularly with the Residents' Council, and in any case, at least every three months, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

A record review of the Residents' Council meeting minutes revealed there was no review of the menu cycles by the Residents' Council.

An interview with the Residents' Council Secretary revealed the Residents' Council had not reviewed the menu cycle.

An interview with the Food Service Supervisor confirmed the Residents' Council had not reviewed the menu cycle and that it was the expectation that the Residents' Council were involved. [s. 71. (1) (f)]

2. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Observations of a residents' room revealed a cup containing a liquid, covered with a cling wrap labeled with resident #022's name, placed on the bed side table with a sealed straw. The resident was listed with a cognitive performance scale (CPS) of four.

The covered cup was observed at multiple times throughout the day.
At an identified time, the cup remained covered and the resident was taken to the dining room for a meal.

An interview with a Nurse Aide confirmed the beverage was placed in the room at a specified time, where it remained covered, and had not been offered to the resident and that it was the expectation that residents were offered a between meal beverage. [s. 71. (3) (b)]

3. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Observations of a residents' room revealed a beverage on the bed side table. The resident was listed with a cognitive performance scale (CPS) of six.

The unaltered beverage was observed on the bedside table at multiple times throughout the day.
At an identified time, the beverage remained on the resident's bed side table and the resident was taken to the dining room for a meal.

An interview with a Nurse Aide confirmed the beverage was placed in the room at a specified time and had not been consumed. Staff confirmed resident had not been offered the drink as the drink would have been open if they had placed the drink to the resident lips.
The Nurse Aide confirmed it was the expectation that residents were offered a between meal beverage. [s. 71. (3) (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 menu cycle was reviewed by the Residents' Council and that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A record review of Residents' Council meeting minutes revealed the dining and snack service times had not been reviewed by the Residents' Council.

An interview with the Residents' Council appointed secretary revealed the Residents' Council had not reviewed the meal and snack times.

An interview with the Food Supervisor confirmed the Residents' Council had not reviewed the dining and snack service times and confirmed it was the expectation that the Residents' Council were involved. [s. 73. (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 the dining and snack service includes a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the following required information was posted in the home:
-The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
-An explanation of the duty under section 24 to make mandatory reports;
-Notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
-An explanation of the protections afforded under section 26.

Observations by Inspector #213 on September 21, 2015, revealed the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports, notification of the home's policy to minimize restraining of residents and an explanation of the protections afforded under section 26 (whistle blowing policy) were not posted in the home.

The Ward Clerk and the Administrator confirmed in interviews with Inspector #213 on September 21, 2015, that this information and these policies were not posted in the home and that they were not aware of the requirement for these items to be posted. [s. 79. (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 the following required information was posted in the home:
-The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
-An explanation of the duty under section 24 to make mandatory reports;
-Notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
-An explanation of the protections afforded under section 26, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

A record review of the Residents' Council meeting minutes revealed the Residents' Council was not involved in developing and carrying out the satisfaction survey.

An interview with the Residents' Council President revealed the Residents' Council was not involved in developing and carrying out the satisfaction survey.

An interview with the Residents' Council Secretary revealed the Residents' Council was not involved in developing and carrying out the satisfaction survey.

An interview with the Administrator confirmed the Residents' Council was not involved in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that they documented and made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

A record review of the 2014 Residents' Council meeting minutes revealed that the licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

An interview with the Residents' Council President revealed the licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey of 2014.

An interview with the Residents' Council Secretary revealed the licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey of 2014.

An interview with the Administrator confirmed the licensee failed to make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey of 2014. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

A) Observations during the Initial tour of the home revealed an accessible tub room with a tub holding approximately five centimetres of cloudy liquid and an unlocked cupboard containing a bottle of disinfectant.

An interview with a Personal Support Worker (PSW) confirmed the tub room door was always unlocked and the liquid in the bath tub was a disinfectant chemical that was left in the bath tub to clean the bath tub. The PSW confirmed the disinfectant in the cupboard was meant to have been locked away.

B) Observations in the Activity lounge revealed two bottles of Acetone nail varnish remover accessible to the four residents sitting in the lounge.

An interview with the Physiotherapist Assistant confirmed the two bottles of Acetone nail varnish remover should have been locked away.

An interview with a PSW confirmed all hazardous substances were to be kept inaccessible to residents at all times.

C) Observations revealed a disinfectant stored in an unlocked cupboard under the sink in the dining room.

An interview with the Food Services Manager confirmed the hazardous substance should not be stored under the sink and it was the home's expectation that hazardous substances were kept inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and identified the training and retraining requirements for all staff.

Review of the home's policy A-8 "Resident Abuse and Neglect" dated January 2012, revealed that there were no interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not identify the training and retraining requirements for all staff.

In an interview with Inspector #213 on September 21, 2015, the Administrator confirmed that the home's policy "Resident Abuse and Neglect" had not been updated since January 2012 and did not include interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected and did not identify the training and retraining requirements for all staff. [s. 96. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and identify the training and retraining requirements for all staff, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented for every use of a physical device to restrain a resident under section 31 of the Act: the circumstances precipitating the application of the physical device and what alternatives were considered and why those alternatives were inappropriate.

An observation of a residents' room revealed the type and number of side rail in use when the resident was not in bed.

A staff interview revealed the resident used a specified type and number of side rails for safety.

The home’s policy R-21 "Restraints", dated July 2015, indicated "the reason for restraint use nursing assessment form must be completed by Registered Staff"

A review of the plan of care for resident #045 revealed the type, number, reason, documentation and monitoring requirements for the use of side rails.

Record review of the health care record on Point Click Care and the paper chart for resident #045 revealed no “Reasons for Restraint Use – Nursing Assessment” form for the type and number of side rails.

In an interview with Inspector #213 on September 25, 2015, a registered staff member confirmed that the use of type and number of side rails was definitely a restraint for resident #045 as the purpose was to prevent them from getting out of bed. The registered staff member confirmed that there was no “Reasons for Restraint Use – Nursing Assessment” form completed for the type and number of side rails for resident #045, and that expectation was that this assessment should have been completed for all restraints in use. [s. 110. (7)]

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 following are documented for every use of a physical device to restrain a resident under section 31 of the Act: the circumstances precipitating the application of the physical device and what alternatives were considered and why those alternatives were inappropriate, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation revealed that resident #015 was crying. Inspector #588 approached the resident in their room, to inquire. The pull cord for the call bell was clipped to the back of their left shoulder, inaccessible to the resident.

During an interview with the PSW, Inspector #588 revealed information regarding the residents crying. The PSW confirmed that the resident could not pull their call bell with the way the pull cord was attached at the back of their left shoulder and that the pull cord should have been attached so that it was accessible to the resident at all times. [s. 17. (1) (a)]

Issued on this 25th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHRISTINE MCCARTHY (588), REBECCA DEWITTE (521), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2015_355588_0024
Log No. / Registre no:	024280-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 24, 2015
Licensee / Titulaire de permis :	MACGOWAN NURSING HOMES LTD 719 Josephine Street, P.O. Box 1060, WINGHAM, ON, N0G-2W0
LTC Home / Foyer de SLD :	BRAEMAR RETIREMENT CENTRE 719 Josephine Street North, R.R. #1, P.O. Box 1060, WINGHAM, ON, N0G-2W0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ARCHIE MACGOWAN

To MACGOWAN NURSING HOMES LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as identify who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Christine McCarthy, Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Christine.M.McCarthy@ontario.ca by December 18, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, under O.Reg.79/10, s.15(2) on August 29, 2014, Inspection #2014_259520_0026.

Observations of all three wings including resident rooms, bathrooms and hallways from September 14 to 23, 2015, by Inspectors #213, #512 and #588 revealed multiple areas of disrepair. Areas of disrepair included scrapes, scuffs, cracks, holes and gouges in walls, doors, door frames, floors and baseboards.

The Administrator and a Maintenance Staff member confirmed in an interview on September 22, 2015 with Inspector #213 that there were multiple areas of disrepair including scrapes, scuffs, cracks, holes and gouges in walls, doors, door frames, floors and baseboards throughout the entire home and that there was no plan in place to remedy these issues.

(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 24th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christine McCarthy

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