Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 29, 2018	2018_580568_0007	005016-18	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Listowel Nursing Home
710 Reserve Avenue South LISTOWEL ON N4W 2L1

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

DOROTHY GINTHER (568), GLORIA KOVACH (697), JANETM EVANS (659), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 29, April 3, 4, 5, 6, 9, 10, 11, 13, 17, 18, 19, 2018.

The following intakes were completed in conjunction with the Resident Quality Inspection:

Follow-up to CO #001, #002, #003 from inspection #025127-17, 025128-17, 025129-17,2017
Follow-up to CO #001 and #002 from inspection #2017_262630_0021 (A2) log #021458-17 and #021457-17
Critical Incident System (CIS) #2664-000017-17 log #021301-17 and CIS #2664-000019-17 log #022575-17 related to alleged abuse;
CIS #2664-000003-18 log #002393-18 related incompetent care or treatment of a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, RAI Coordinator, Ward Clerk, Activity Director, Registered Dietitian, Restorative Care Aide, a maintenance staff, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, Security Guards, a Residents' Council representative, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, medication incidents; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 245.	CO #001	2017_600568_0015	532
O.Reg 79/10 s. 51. (2)	CO #002	2017_600568_0015	532
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2017_262630_0021	532
O.Reg 79/10 s. 9. (1)	CO #901	2017_262630_0021	532
O.Reg 79/10 s. 9. (1)	CO #001	2017_262630_0021	532

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behaviour triggers for the resident were identified, where possible.

A Critical Incident System (CIS) report was submitted to the Director which identified an allegation of resident to resident abuse.

Progress notes for a specified date stated that a Personal Support Worker (PSW) informed a registered staff that a resident reported that they had been abused by another resident. On assessment there were no visible injuries or bruises, however the resident said that they were sore to touch. Documentation did not identify where the resident was sore. The Director of Care (DOC) was informed of the incident by registered staff.

Review of the progress notes identified that there was a history of altercations between the two specified residents.

In an interview with two staff, they told the Inspector that the presence of a specified co-resident would often trigger the identified resident's responsive behaviours.

A PSW stated that they recalled the incident between the two residents described in the specified CIS report. The PSW said that a resident reported to a staff member that another resident had physically abused them. The PSW said there had been incidents in the past between these two residents.

The Home's Policy and Procedure for Resident Behaviour Management last reviewed

July 2016, stated that the care plan for behaviours would be updated by the multidisciplinary team to include a resident's behaviours, known triggers and interventions.

The identified resident's care plan for behaviours did not identify that the specified co-resident was a potential trigger for their behaviours despite a history of altercations between the two residents and staff reporting that it was a trigger.

The licensee has failed to ensure that the behaviour triggers for the specified resident were identified. [s. 53. (4) (a)]

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CIS report was submitted to the Director which stated that during an assessment by an external source a resident alleged that another resident in the home had been abusive towards them on more than one occasion. This was documented and the information was shared with the home.

A report sent to the home confirmed the information found in the CIS report and further indicated that a specified organization would be consulted regarding additional supports.

Progress notes identified a history of responsive behaviours and altercations between the two identified residents which took place prior to the identified assessment.

A Behavioral Supports Ontario (BSO) referral note stated that a specified resident had exhibited responsive behaviours towards other resident's including the specified co-resident.

The plan of care for the specified resident identified strategies and interventions related to the resident's behaviours, but they were only put in place after the co-resident expressed their concerns during the identified assessment.

A Registered Practical Nurse (RPN) and A Restorative Care Aide (RCA) recalled that the identified resident had exhibited responsive behaviours towards a specified co-resident for some time. The RPN said that the specified co-resident told them that that the identified resident had exhibited responsive behaviours which resulted in an injury to them. The RPN confirmed that based on their assessment the resident had been

injured. The incident was reported to the RN on duty and the identified resident was encouraged not to interact with the co-resident.

The home's BSO staff and Ward Clerk said that BSO received a referral for the identified resident in relation to their responsive behaviours. The BSO staff acknowledged that while interventions were put in place at that time they were not added to the resident's plan of care. The BSO staff said that it was not until after the resident was assessed by the external source and they were made aware of the resident's complaints of abuse that BSO became more involved with the identified resident. The home then identified and implemented strategies to minimize the altercations between the two residents.

The DOC said they were aware of altercations between the identified residents but they were not informed of the incident where the specified co-resident was injured. The DOC said that they did not look at this incident as abuse but felt it was more related to the resident's diagnoses and related cognitive impairment. Once notified by the external source of the alleged abuse by another resident strategies were put to minimize the risk of further altercations.

The licensee failed to ensure that strategies were developed and implemented to respond to the identified resident's responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident.

a) A resident was identified as being at high risk for incontinence with worsening bowel or bladder incontinence according to the most recent Minimum Data Set (MDS) assessment relative to the previous assessment.

The plan of care for the resident specific to toileting stated that the resident required a specified level of assistance from a specified number of staff at certain time during the day.

The MDS quarterly review assessment identified that the resident had a specified level of incontinence of bowel and bladder. The previous MDS quarterly review assessment identified that the resident was incontinent of bowel and bladder but to a lesser degree than the more recent assessment.

The resident's substitute decision maker (SDM) told the Inspector that staff assisted the

resident with toileting.

A PSW shared that the resident was assisted with toileting throughout the day. The PSW explained that because of a change in the resident's condition their toileting needs had changed. The PSW reported that the kardex / care plan did not reflect the resident's current toileting needs and what was being done. The routine toileting conducted by staff during the day was not reflected in the Kardex / care plan.

The plan of care was reviewed with the RAI Coordinator and they stated that if toileting was being provided at intervals throughout the day then it should be reflected in the plan of care for the resident, but it was not.

b) On two specified dates a device was observed in place for a specified resident.

A PSW said they believed the resident had the device to assist with their activities of daily living. To be sure of what the device was to be used for they would have to check the identified resident's Kardex on point of care (POC).

The most recent MDS assessment for the resident documented under devices that the resident had none. The plan of care for the resident including the Kardex did not contain any documentation to identify that the resident needed the specified device.

A Registered Nurse (RN) told told the Inspector that the resident was to have the device to assist with their activities of daily living. The RN acknowledged that that plan of care did not identify that the resident was to have the device in place. (568) [s. 6. (1) (a)]

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

A CIS report was submitted to the Director which described an incident of alleged resident to resident abuse.

Ministry of Health and Long Term Care (MOHLTC) after hours report stated that at the time of the reported incident a specified intervention to minimize the risk of altercations with other residents was not in place.

The behaviour plan of care for the resident documented that specific strategies were to be implemented to address the resident's responsive behaviours and to minimize the risk

of altercations.

Review of the Standing Operating Procedures Caressant Care Listowel, 8.0 Specific Shift Duties dated December 1, 2017, outlined parameters for a specified strategy being implemented to address the resident's behaviours..

During the inspection multiple observations were conducted where it was noted that the specified strategy was not being implemented.

The DOC stated that the specified strategy had been put in place in order to mitigate the risk of altercations with other residents due to the identified resident's history of responsive behaviours.

The licensee has failed to ensure that the care set out in the plan of care to responsive behaviours was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

a) The identified MDS assessment stated that the resident was on medication for a specified illness. The resident was identified as having some degree of bowel and bladder incontinence.

The plan of care for toileting stated that the resident required a specified level of assistance by staff.

The identified resident stated that they often toileted themselves and they would only call for assistance afterwards on an as needed basis.

A PSW and the RAI Coordinator stated that the identified resident was not well for a period of time during which the level of assistance for their activities of daily living was greater. Since they recovered they do not require the same level of assistance.

The RAI Coordinator stated that the plan of care for the identified resident had not been updated to reflect the change in the resident's health condition and need for greater assistance with their activities of daily living. The RAI Coordinator acknowledged that the plan of care should have been updated by the registered staff when the care needs

changed for the identified resident.

b) During two observations on a specified date, a resident was observed asleep in their bed.

Review of the resident's most recent MDS assessment identified that when the resident was awake, not getting treatment or assistance with activities of daily living care, they were involved in activities for a specified time during the seven day observation period. Several activities were listed as a preference. The extent of resident involvement in activities was reported as not having changed.

The Multi-Day Participation report for a nine day period for the identified resident was reviewed and it documented that the resident's average daily participation in activities for the nine day period was much less than what was documented in the MDS assessment.

The plan of care for the identified resident included preferred activities and the goal that the resident would participate in two to three activities a week.

The Activity Director (AD) stated that on admission the resident and/or a family member was given a form to record the resident's interests, previous activities, life routines, and spiritual background. The completed form was given to the AD to assist with care planning for the resident's activities. The AD stated that recently the resident had stopped attending activities because of a change in their health status. The AD said that recreation did not currently reassess and update the plan of care for residents in terms of their activity participation. (568)

c) A Resident was observed asleep in bed on three separate afternoons during the inspection.

The plan of care for the resident identified specific activities that they enjoyed, with a goal for the resident to participate in two to three activities a week without prompting.

The Resident's most recent MDS assessment documented that when the resident was awake, not getting treatment or activities of daily living care, they were involved in activities for a specified time over the last seven days. The extent of resident involvement in activities was reported as not having changed.

The Multi-Day Participation report for a specified eight day period for the resident stated

that the resident's average daily participation in all activities was much less than that documented in the most recent MDS assessment.

The AD stated that more recently the resident's attendance at activities had declined. The AD said that recreation did not currently reassess and update the plan of care for residents in terms of their activity participation. (659)

The licensee failed to ensure that the identified residents were reassessed and the plan of care 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. [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 there was a written plan of care for each resident that sets out, the planned care for the resident;
that the plan of care sets out clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care was provided to the resident as specified in the plan; and that residents are
reassessed and the plan of care 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 is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

Ontario Regulation 79/10 s.2 (1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

A CIS report was submitted to the Director which stated that a resident had been assessed by an external source. During their assessment, the resident alleged that another resident in the home had been abusive towards them. This was documented and the information was shared with the home.

Progress notes identified a history of responsive behaviours and altercations between the two identified residents which took place prior to the hospital admission .

A Registered Practical Nurse (RPN) and Restorative Care Aide (RCA) recalled that the identified resident had exhibited responsive behaviours towards a specified co-resident for some time. The RPN said they recalled the incident where the co-resident told them that the identified resident had exhibited responsive behaviours which resulted in an injury to them. The RPN confirmed that based on their assessment the resident had been injured. The incident was reported to the RN on duty and the identified resident was encouraged not to interact with the co-resident.

The BSO staff and Ward Clerk said that BSO received a referral for the identified resident in relation to their responsive behaviours. The BSO staff acknowledged that while interventions were put in place at that time they were not added to the resident's plan of care. The BSO staff said that it was not until after the resident was assessed by the external source and they were made aware of the resident's complaints of abuse that BSO became more involved with the identified resident. At that point the home identified and implemented strategies two minimize the altercations between the two residents.

The DOC said they were aware of the history of altercations between the identified residents but they were not informed directly of the incident where the specified co-resident was injured. The DOC said that they did not look at this incident as abuse but felt it was more related to the resident's diagnoses. The DOC acknowledged that they had not implemented specific strategies to minimize the risk of altercations between the two residents until after they were notified by the external source of the alleged abuse.

The licensee failed to protect resident #060 from abuse by another resident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 improper or incompetent treatment or care of a resident, which resulted in harm or risk of harm to the resident had occurred or may occur should immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director for an incident where a resident was assessed as having specified injury.

A progress note documented that a PSW reported that they noted an area of altered skin

integrity. The area was assessed and the resident complained of pain. Registered staff spoke with the physician and they were advised the resident needed further evaluation.

Review of an email from the Executive Director (ED) to a staff member at the Home's corporate office documented that a resident had a suspicious injury and that an investigation was ongoing.

The DOC stated "we didn't know what had happened" and that they had completed an investigation and interviewed staff to ensure that the altered skin integrity was not related to resident care in the Home.

The ED stated that the incident of alleged improper or incompetent treatment or care involving the resident should have been reported to the Director immediately and acknowledged that it had not. [s. 24. (1)]

2. During the inspection of a CIS report related to an incident of alleged resident to resident abuse, the identified residents' clinical record showed a history of altercations between the two residents.

A progress note documented that during one of the altercations the identified resident exhibited responsive behaviours towards a co-resident which resulted in an injury.

The home's policy titled "Abuse and Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff" dated February 2018, stated that the ED/DOC who had reasonable grounds to suspect that abuse by anyone had occurred or may occur must immediately report that suspicion and the information upon which the suspicion was based to the Director appointed by the Ministry of Health and Long Term Care.

The licensee failed to report to the Director the incident of alleged abuse of a resident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident, which resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The "CC Pain Assessment Tool" for an identified resident documented that the resident had pain. The assessment stated that medication made the pain better and that the level of pain the resident was satisfied with was no pain.

Review of the most recent MDS assessment showed the resident had symptoms of pain at a specified frequency and intensity at the identified sites.

The resident verbalized pain to the Inspectors on several occasions during the inspection.

The electronic medication administration record (eMAR) for a specified period showed

that the resident had a regularly scheduled dose of medication for pain relief as well as an as needed (prn) dose. The eMAR documentation showed that on several occasions during the specified time period the pain medication was ineffective to manage the resident's pain.

The Home's policy titled Pain Assessment reviewed April 2018, documented that all residents with pain would have their pain assessed and treated. The procedure outlined the following:
"1. Residents who score a two (2) or higher on any MDS RAI assessment under section J2 will have a further pain assessment completed using the Caressant Care Pain Assessment tool on Point Click Care. This assessment will also be utilized when : a new pain medication is initiated, a resident exhibits behaviour that may herald the onset of pain, a resident complains of pain of 4 or greater, a resident exhibits distress related behaviours or facial grimace, a resident/family/staff/volunteers indicate pain is present
2. The Pain Management Flow sheet (PMFS), will be utilized, when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions (see Appendix B). This initiation is based upon evidence gathered using the Caressant Care pain Assessment tool to ensure that those with identified pain are monitored and that pain is brought under control."

The Registered Nurse (RN) stated that if a resident's pain was unrelieved they would try to administer Tylenol or they would call or fax the doctor. When asked if they would complete an assessment of the resident, the RN said yes. The RN reviewed the documentation from the identified resident's eMAR with the Inspector for the documented incidents of unrelieved pain during the specified time period. The RN acknowledged that there was no assessment completed related to these incidents nor was there a pain flow sheet completed.

A RPN stated that the identified resident had a change in their complaints of pain and that it was being monitored. When asked about the process to manage pain when medication was ineffective, the RPN stated they would try a new medication, but acknowledged that they had not done this for the identified resident and they had not completed a pain flow sheet.

The DOC said that if a resident's pain was not relieved with a scheduled medication and they had a prn they would try that for unrelieved pain. If both routine and prn medications did not work, then the RN was to fax to the doctor right away and provide information on what had been trialed for medication and non medication pain management. The DOC

stated they had not used a pain flow sheet in the Home during the last three years they had worked there. They further said that where initial pain interventions were ineffective for the identified resident, the expectation was that a pain assessment be completed. The DOC confirmed that a pain assessment was not completed for the identified resident.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program included the development and implementation of a schedule of recreation and social activities that were offered during days, evenings and weekends.

Several residents in the home shared that there were no activities available later in the day and in the early evening, and very little happening in the home over the weekend in terms of activities.

The Home's activity calender for April 2018 had no activities scheduled beyond 1400 hours. Review of the activity calendar for February and March 2018 identified one evening activity on Saturday February 24, 2018 at 1900 hours, otherwise the last scheduled activity was at 1400 hours.

The Activity Director (AD) told Inspectors that they worked full time days Monday to Friday, and were the only program staff aside from co-op students and volunteers that assisted with activities. When asked if they ran programs in the evening and on weekends, the AD said that it was hit and miss because they only worked during the day. They said that they occasionally organized a band on a Saturday night but not often.

The licensee failed to ensure that the program included the development and implementation of a schedule of recreation and social activities that were offered during the evening. [s. 65. (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 the program included the development and implementation of a schedule of recreation and social activities that were offered during days, evenings and weekends, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

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

Review of the Residents' Council (RC) monthly meeting minutes for the period of October 2017 through March 2018, documented that the results of the 2017 satisfaction survey was presented and reviewed at a Residents' Council meeting. The minutes did not state that the licensee had sought the input of the RC in developing and carrying out the satisfaction survey.

During an interview with the RC representative they told an Inspector that they attended most of the monthly RC meetings. When asked if they could recall if the RC was asked for input regarding the development and carrying out of the satisfaction survey, they said they were not aware of this unless it took place at a meeting they did not attend.

In interviews with the RC staff liaison and the ED they said that the satisfaction survey was developed by their corporate office. The ED said that they did not seek the advice of the Residents' Council in the development and carrying out of the satisfaction survey.

The licensee failed to ensure that the licensee has sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (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 licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

During multiple observations over several days the door to the documentation / treatment room was found unlocked. The room contained hard copy of resident charts as well as a treatment cart (unlocked) which contained lotions, prescription creams and ointments for residents. The locking mechanism on the door required staff to enter a code and turn a knob in order to enter the room, and again when leaving the room in order to secure the area.

Three registered staff acknowledged that the door to the documentation / treatment room was unlocked and should be locked at all times.

The Executive Director acknowledged that the expectation was that the door to the documentation / treatment room was to be locked at all times.

The licensee has failed to ensure that the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A CIS report was submitted to the Director which reported an incident of resident to resident abuse.

The information in the CIS report stated that an individual was questioned and said there was an altercation between two residents. Another individual said they did not see any altercation from their angle but according to the MOHLTC after hours incident report the individual was not in the direct vicinity of the residents at the time of the alleged altercation.

When the Inspector asked the DOC for a copy of the incident investigation related to the CIS report, the DOC said that the only documentation of the incident was on the CIS report and there was no documented incident investigation. The DOC stated that there was nothing to substantiate that anything happened. When asked if they had interviewed the PSW who reported the incident, the DOC stated that they had, but could not recall what was said and there was no documentation of the interview. The DOC also shared that they had not interviewed the residents involved in the incident.

The Homes policy titled "Abuse and Neglect - Staff to Resident, Resident to Resident, Family to Resident , Resident or Family to Staff" reviewed February 2018, stated that the home would immediately investigate all incidents of alleged, suspected or witnessed incidents of abuse or neglect. As part of the investigation, the DOC would interview both residents involved in an incident and the home's internal incident report form would be completed.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. S.23.(1) [s. 23. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the inspection a resident was identified as having a new area of altered skin integrity.

Review of the resident's Treatment Administration Record (TAR) and Initial Skin Assessment identified an area of altered skin integrity. The TAR did not indicate that a weekly skin assessment had been completed during a specified period of 20 days. Progress notes for the dates when the weekly assessments should have been completed stated that the camera on the home's skin and wound application was not working.

In an interview with a RN they said that once an area of altered skin integrity was identified they would conduct an initial skin assessment utilizing their skin and wound application on an iPod. The information would then be downloaded to Point Click Care (PCC). Weekly assessments of the altered skin integrity would follow until the area had healed. The RN said that they had not completed the weekly skin assessments for the identified resident during a specified period of time because the camera and application that they used for skin and wound assessments was not working. The RN acknowledged that an alternative skin and wound assessment should have been conducted during this time period and documented in the resident's clinical record.

The licensee failed to ensure that the resident's altered skin integrity was reassessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The home's policy Odour Control, reviewed August 2017, documented "the Nursing Home shall make every reasonable effort to provide an environment free from unpleasant odour, pollutants or irritants. The procedure documented "Provision of air fresheners in areas particularly affected by odour is the responsibility of the housekeeping staff" and "bed pans and bottles should be rinsed immediately after being used".

The home's policy Environment Odour Control, dated August 2017, documented "An environment free from unpleasant odours related to problems of incontinence shall be maintained". The procedure documented "soiled bedpans/urinals should be removed and cleaned after every use; sprays or deodorizers etc., can be used for specific problems but should not be used to mask the cause and commodes, bedpans, urinals should be disinfected after each use".

Multiple observations completed of a specified room showed a lingering odour in the room and in the hall near the room. Observations showed a piece of equipment used for toileting that had not been emptied. There were no deodorizers noted in the room at the time.

In interviews the Ward Clerk, two housekeepers, a contract staff, a maintenance staff, two PSWs, and the ED all acknowledged an ongoing offensive odour in the identified room. They stated that residents in the room were known to be incontinent and sometimes this affected furnishings in the room.

Two housekeepers stated that in the past, they had tried to use Lysol spray to eradicate the odour but they no longer used this and no other product had been provided to manage the odour. The housekeepers stated they used Oxlivir as a disinfectant but it did not control the odour.

The ED stated that they had tried a product in the past to manage the odour through cleaning of the room but it was not effective and caused side effects to the staff who used the product. They stated that they had put an order in for maintenance to re-caulk the bathroom but they believed the tiles may need to be replaced. The ED also said that

continence equipment should be collected and cleaned on night shift and they should also be rinsed after each use; the ED stated that their policies gave them different information related to cleaning and they acknowledged that their policy had not been followed in that continence equipment had not being disinfected after each use.

The licensee has failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Issued on this 9th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), GLORIA KOVACH (697), JANETM EVANS (659), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_580568_0007
Log No. / No de registre :	005016-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 29, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Listowel Nursing Home 710 Reserve Avenue South, LISTOWEL, ON, N4W-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lenora Bell

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_600568_0015, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with r. 53 (4) (a) and (b) of the regulations.

Specifically the licensee must:
a) Ensure that the behavioural triggers for resident #020 and any other resident demonstrating responsive behaviours are identified and documented in the plan of care.
b) Ensure that strategies are developed and implemented to respond to resident #038 and any other resident demonstrating responsive behaviours and that these strategies are documented in the plan of care.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #003 from inspection #2017_600568_0015 served on September 26, 2017, with a compliance date of November 24, 2017.

The licensee was ordered to ensure that for resident #013, resident #007 and any other resident residing in the home that exhibits behavioural symptoms characterized by wandering and risk of elopement, that:
a) behavioural triggers are identified
b) strategies to mitigate the risk of these behaviours are developed and

implemented
c) the effectiveness of these strategies are evaluated and when they are not effective new strategies are implemented in order to ensure the safety of the residents.

The licensee completed all steps of CO #003 but they were not in compliance with O.Reg. 79/10, s. 53 (4) (a) (b).

The severity of this issue was a level 2 as there was potential for actual harm to the residents. The scope was level 2, as two out of four residents demonstrating responsive behaviours did not have triggers identified or strategies developed and implemented to respond to these behaviours. Compliance history was a level 4 as there was ongoing non-compliance despite previous action taken by Ministry. Related non-compliance included:
Compliance order (CO) made under r. 53. (4) (a) (b) of the Regulations, September 26, 2017, (#2017_600568_0015) with a compliance date of November 24, 2017.

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behaviour triggers for the resident were identified, where possible.

A Critical Incident System (CIS) report was submitted to the Director which identified an allegation of resident to resident abuse.

Progress notes for a specified date stated that a Personal Support Worker (PSW) informed a registered staff that a resident reported that they had been abused by another resident. On assessment there were no visible injuries or bruises, however the resident said that they were sore to touch. Documentation did not identify where the resident was sore. The Director of Care (DOC) was informed of the incident by registered staff.

Review of the progress notes identified that there was a history of altercations between the two specified residents.

In an interview with two staff, they told the Inspector that the presence of a specified co-resident would often trigger the identified resident's responsive behaviours.

A PSW stated that they recalled the incident between the two residents described in the specified CIS report. The PSW said that a resident reported to a staff member that another resident had physically abused them. The PSW said there had been incidents in the past between these two residents.

The Home's Policy and Procedure for Resident Behaviour Management last reviewed July 2016, stated that the care plan for behaviours would be updated by the multidisciplinary team to include a resident's behaviours, known triggers and interventions.

The identified resident's care plan for behaviours did not identify that the specified co-resident was a potential trigger for their behaviours despite a history of altercations between the two residents and staff reporting that it was a trigger.

The licensee has failed to ensure that the behaviour triggers for the specified resident were identified.

(697)

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CIS report was submitted to the Director which stated that during an assessment by an external source a resident alleged that another resident in the home had been abusive towards them on more than one occasion. This was documented and the information was shared with the home.

A report sent to the home confirmed the information found in the CIS report and further indicated that a specified organization would be consulted regarding additional supports.

Progress notes identified a history of responsive behaviours and altercations between the two identified residents which took place prior to the identified assessment.

A Behavioural Supports Ontario (BSO) referral note stated that a specified resident had exhibited responsive behaviours towards other resident's including the specified co-resident.

The plan of care for the specified resident identified strategies and interventions related to the resident's behaviours, but they were only put in place after the co-resident expressed their concerns during the identified assessment.

A Registered Practical Nurse (RPN) and A Restorative Care Aide (RCA) recalled that the identified resident had exhibited responsive behaviours towards a specified co-resident for some time. The RPN said that the specified co-resident told them that that the identified resident had exhibited responsive behaviours which resulted in an injury to them. The RPN confirmed that based on their assessment the resident had been injured. The incident was reported to the RN on duty and the identified resident was encouraged not to interact with the co-resident.

The home's BSO staff and Ward Clerk said that BSO received a referral for the identified resident in relation to their responsive behaviours. The BSO staff acknowledged that while interventions were put in place at that time they were not added to the resident's plan of care. The BSO staff said that it was not until after the resident was assessed by the external source and they were made aware of the resident's complaints of abuse that BSO became more involved with the identified resident. The home then identified and implemented strategies to minimize the altercations between the two residents.

The DOC said they were aware of altercations between the identified residents but they were not informed of the incident where the specified co-resident was injured. The DOC said that they did not look at this incident as abuse but felt it was more related to the resident's diagnoses and related cognitive impairment. Once notified by the external source of the alleged abuse by another resident strategies were put to minimize the risk of further altercations.

The licensee failed to ensure that strategies were developed and implemented to respond to the identified resident's responsive behaviours. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2018

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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 29th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

Service Area Office / Bureau régional de services : Central West Service Area Office