Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2017	2017_606563_0009	009951-17	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 ON MARY BUCKE
4 MARY BUCKE STREET ST. THOMAS ON N5R 5J6

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

MELANIE NORTHEY (563), DONNA TIERNEY (569)

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): May 29, 30, 31, June 1 and 2, 2017

The following intakes were completed within the RQI:
015160-16- Critical Incident related to a fall
013371-16- Follow Up related to water temperatures
010787-16- Follow Up related to policy

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Resident Assessment Instrument Coordinator, the Occupational Therapist, the Activities Coordinator, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Residents' Council
Skin and Wound Care

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

10 WN(s)
8 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. 90. (2)	CO #001	2016_262523_0017	563

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. 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 :

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

The Resident Quality Inspection (RQI) #2016_326569_0005 Compliance Order (CO) #001 with a compliance date of April 18, 2016 stated the following:

The licensee must take immediate action to achieve compliance with O.Reg 79/10, s.8. (1) (b).
The licensee must ensure that the home's policy "Pain Assessment" is complied with, including but not limited to the following:
1. For any resident who scores a two or higher on any RAI MDS assessment under section J2
2. When a resident indicates pain is present.
The home must also ensure that all direct care staff receive education related to the policy.

The "Pain Assessment" policy last revised May 2015 stated the following:
"1. Caressant Care recognizes the RAI MDS as a comprehensive assessment. 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 (see Appendix A). This assessment will also be utilized when: a new 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."

A) Record review of a "Pain" progress note in PointClickCare (PCC) stated a resident showed increased signs of discomfort.

The current care plan for the resident stated the resident had actual pain.

The "CC Pain Assessment Tool" in PCC was not completed related to the resident's discomfort as documented in the pain progress note.

Review of the Minimum Data Set (MDS) assessment section J2 documented there was an increase in the resident's pain from the previous quarterly assessment. There was no pain assessment completed until one month later.

There was no documented evidence in the resident's clinical record that a Pain Management Flow Sheet (PMFS) was completed when the resident experienced obvious discomfort with physical signs of pain.

B) Record review of the "Pain" progress note stated a resident displayed behaviours and admitted to having generalized discomfort with only some effect noted after the administration of a pain medication.

The current care plan for the resident stated the resident had specific pain.

The "CC Pain Assessment Tool" in PCC was not completed for the resident since admission.

The Resident Assessment Instrument Coordinator (RAI-C) shared that if the MDS section J2 documented a pain score of 2 or greater, then the resident's name would be added to a schedule for completion and that the registered staff were to refer to this schedule posted in the medication room and nursing office. The RAI-C shared that the pain assessment would also be completed with the onset of new pain or when new pain medication was started.

There was no documented evidence in the resident's clinical record that a Pain Management Flow Sheet (PMFS) was completed when the resident experienced generalized discomfort with only some effect noted after the administration of a pain medication.

The Registered Practical Nurse (RPN), the Registered Nurse (RN) and the Director of Nursing (DON) verified that the Pain Management Flow Sheet (PMFS) was no longer used by any registered staff, and a pain or vital sign progress note was now completed instead.

The DON acknowledged that a pain assessment was to be completed in PCC according to the home's policy.

C) Review of the staff sign in sheet related to the pain education in March 2016 documented that of the 11 registered staff members, three did not receive the education related to the pain assessment policy. Also, of the 36 Personal Support Workers (PSW), six PSWs did not receive the education.

The DON shared that the "Pain Assessment" policy was read to the direct care staff at shift change during the month of March 2016. The DON shared that direct care staff also completed the "Pain Management Test" after the education session. The DON acknowledged that three registered staff and six PSWs did not receive the education related to the pain policy. The DON verified that education related to pain has not yet been completed for 2017.

The licensee failed to ensure that the Pain Assessment policy was complied with for these two residents and the licensee failed to ensure that all direct care staff received education related to the Pain Assessment policy.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 16, 2016 as a Compliance Order (CO) in the Resident Quality Inspection (RQI) #2016_326569_0005, issued on April 13, 2016 with a compliance date of April 18, 2016, and issued on June 11, 2015 as a Written Notification (WN) in the RQI #2015_355588_0015. [s. 8. (1) (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).

Findings/Faits saillants :

The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The resident was observed sitting in their room with a personal assistance services device (PASD) in use. During these observations, the resident was asked if they could remove the PASD. During both instances the resident did not attempt to remove it.

The resident's clinical record stated in the current care plan and kardex that the resident used a PASD and that the resident was able to remove it. The current tasks in POC stated the resident uses a PASD, but here were no tasks documented related to the monitoring or specific use of the PASD.

A PSW said that they have never seen the resident remove their PASD and additionally the PSW was not sure why the resident used a PASD and did not know when the PASD should be applied or removed. For all resident care requirements, the PSW referred to the kardex and the task list on Point of Care (POC).

A Health Care Aide (HCA) shared that the resident used the PASD for a specific reason. When asked what the specific instructions were for PSWs related to the application and removal of the PASD, the HCA said they did not know and that they always applied the PASD at a specific time, and took the PASD off when the resident went back to bed. The HCA also said they did not think there were any instructions on the kardex that provided specific details related to the PASD.

The DON acknowledged that there was no clear direction related to the PASD interventions because the plan of care did not clearly state what the tasks were to be completed for the resident's PASD.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 6. (1) (c)]

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 is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint by a physical device was included in the plan of care.

The resident shared that staff applied a physical device and that the resident was unable to release the physical device without staff assistance.

The resident was observed with the physical device in use on multiple occasions.

The resident's clinical record did not have tasks documented in POC related to the monitoring or use of the physical device, there were no goals or interventions related to the use of the physical device in the resident's current care plan and there was no assessment completed in PCC. There was no documentation in the resident's progress notes in PCC related to the use of the physical device.

The Minimum Data Set (MDS) assessments completed in PCC for question P4c related to the use of a trunk restraint was answered "0. Not used" since admission.

A PSW shared that as soon as the resident was out of bed, the physical device was

applied. The PSW stated the resident would instruct staff to apply the physical device and verified that the resident was unable to release the physical device.

The Director of Nursing (DON) shared that the resident does use a physical device and acknowledged that at one time the resident was able to remove the physical device, but that the resident was no longer able to release the physical device on their own. The DON also verified that there were no goals or interventions related to the use of this device in the current plan of care.

The Occupational Therapist (OT) shared that the resident was admitted to the home with the use of a physical device. The OT acknowledged that the resident does not have any assessment documentation related to the need for or the use of the physical device. The OT shared that the resident did require multiple physical devices for safety reasons.

Two Personal Support Workers (PSWs) shared that the resident's physical device was always applied when the resident was out of bed. Both PSWs acknowledged that there were no interventions on the kardex to instruct staff that the resident used a physical device or when to apply the physical device. The PSWs verified there was no monitoring of the physical device as a task in Point of Care (POC).

The licensee has failed to ensure that the physical device restraint was included in the plan of care.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 31. (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 the restraint by a physical device is included in the plan of care, to be implemented voluntarily.

WN #4: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

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 personal assistance services device (PASD) described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

Note: "Subsection (1) applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able, either physically or cognitively, to release them self from the PASD."

The resident shared that they were unable to release the PASD.

The resident was observed with two PASDs in use. The PSW staff were observed transporting the resident with the PASD in use.

The “Occupational Therapy” progress note in PCC stated the resident used a specific PASD for positioning.

Review of the progress notes for the use of the PASD noted the resident was able to undo the PASD. There was no further progress note documentation related to the use of the PASD or the resident's physical inability to now release the PASD.

The resident’s clinical record did not have tasks documented in POC related to the monitoring or use of the PASDs, there were no goals or interventions related to the use of the PASDs in the resident's current care plan and there was no assessment completed in PCC.

The “Personal Assistive Service Devices (PASD)” policy last reviewed July 2016 stated, “For PASD's which limit movement where the resident is not cognitively or physically able to remove the PASD, the following shall apply: All residents who require the use of a PASD to perform activity of daily living, shall have this documented in the Plan of Care.”

The DON shared that the resident used PASDs and acknowledged that there were no goals or interventions related to the use of either device in the current plan of care.

Two Personal Support Workers (PSWs) shared that the resident’s PASD had always been applied when the resident was out of bed and that the other PASD was used for positioning and comfort. Both PSWs acknowledged that there were no interventions on the kardex to instruct staff that the resident used PASDs or when to apply them, that there was no monitoring of the PASDs as a task in POC.

The Occupational Therapist (OT) acknowledged that the resident did not have any assessment documentation related to the need for or the use of PASDs. The OT shared

that there was no referral for an assessment and that the resident needed the PASDs as a safety measure.

The licensee has failed to ensure that the PASDs that were used to assist the resident with a routine activity of living was included in the residents' plan of care.

2. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if alternatives to the use of a PASD have been considered, has been approved by any person provided for in the regulations, and has been consented to by the resident, or substitute decision-maker of the resident.

The resident was observed sitting in their room with a personal assistance services device (PASD) in use. During these observations, the resident was asked if they could remove the PASD. During both instances the resident did not attempt to remove it.

The resident's clinical record stated in the current care plan, kardex and tasks, that the resident used a PASD.

A PSW shared that the resident used the PASD to assist with a routine activity of living. When asked if the resident could remove the PASD, the PSW said they have never actually witnessed the resident remove their lap tray.

The DON said that any resident requiring a lap tray should have a referral made to the Occupational Therapist (OT) who would then provide the assessment.

The "Personal Assistive Service Devices (PASD)" policy last reviewed July 2016 stated, "For PASD's which limit movement where the resident is not cognitively or physically able to remove the PASD, the following shall apply:
- Alternatives to the use of PASD'S which limit movement shall be considered and tried where applicable
- All PASD's which limit or restrict movement and where the resident is unable to cognitively or physically remove must be approved by one of the following. Approval shall be noted in the plan of care: Registered Nurse or registered Practical Nurse, Physician, Physiotherapist, Occupational Therapist, Nurse Practitioner
- The resident must consent to the PASD. If the resident is incapable, then the authorized SDM shall give consent. Consent shall be noted in the plan of care.

Review of the resident's clinical record which included the electronic version and hard copy documents, failed to show any documented evidence that a referral, an assessment which included alternatives to the use of the PASD, or a signed consent was completed for the use of the PASD.

The OT acknowledged that the resident did not have any assessment documentation related to the need, use, or alternatives to their PASD. The DON also acknowledged that the resident required their PASD for a routine activity of living and that there was no assessment or consent for this PASD.

The licensee failed to ensure that the resident's PASD included in their plan of care had been approved by the OT, alternatives to its use considered, and consented to by the resident and or authorized substitute decision-maker.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 33. (4) 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 the PASD described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care, and to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if alternatives to the use of a PASD has been considered, has been approved by any person provided for in the regulations, and has been consented to by the resident, or substitute decision-maker of the resident, to be implemented voluntarily.

WN #5: 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 :

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

The Pixalere electronic documentation system for wound care used by the home to document skin and wound assessments was reviewed with the Registered Practical Nurse (RPN). Pixalere was specifically designed for skin and wound assessments and acts as a clinically appropriate assessment instrument capturing all appropriate skin and wound documentation, monitoring, assessment and treatment.

The RPN shared that the resident had altered skin integrity. The RPN acknowledged that the wound was initially assessed in Pixalere, but that there were no wound assessments completed at least weekly. The RPN verified that the resident was to be reassessed at least weekly by a member of the registered nursing staff for all areas of skin breakdown.

The DON verified that all skin and wound assessments were completed in the Pixalere electronic documentation system and no other means of documentation in the resident's clinical record demonstrated that an assessment would be completed. The DON acknowledged that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, should be reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 16, 2016 as a Written Notification (WN) in the Resident Quality Inspection (RQI) #2016_326569_0005. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

An initial record review in PointClickCare (PCC) for three residents documented that there were no completed assessments for incontinence documented in PCC under the "Assessment" tab for the resident since admission.

The Minimum Data Set (MDS) assessments in PCC documented that the residents were incontinent in section H1a since admission.

Three Personal Support Worker (PSWs) shared that the residents were totally incontinent.

The "Bladder and Bowel Management Program" policy last reviewed September 2016 stated, "Complete the Caressant Care Continence Assessment on all residents who score a two (2) or higher on section H1a or H1b of any MDS assessment or at any time upon resident change of status."

The "Assessment of Residents" policy last reviewed July 2016 stated within seven days of admission the nursing department was to have completed the "Caressant Care Continence Assessment on Point Click Care for residents scoring 2 or higher on the MDS assessment."

The Resident Assessment Instrument Coordinator (RAI-C) stated there were a number of residents that did not have the "Caressant Care Assessment of Resident Continence Status 1" assessment completed. The RAI-C acknowledged that these three residents did not have a continence assessment completed since admission.

The licensee has failed to ensure that the residents who were incontinent received a Caressant Care Continence Assessment.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 51. (2) (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 resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred

to in section 36 of the Act was undertaken on a monthly basis; that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee’s policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation; that the results of the analysis undertaken were considered in the evaluation; that the changes or improvements were promptly implemented; and that a written record of everything and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented was promptly prepared.

There was no documented evidence that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis. There was no written record that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee’s policy under section 29 of the Act and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The DON was unsure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis. The DON shared that a Restraint Care Audit was done for the two residents that use bed rails as a restraint, but that the care audit was not an analysis. The DON shared that the only analysis of restraints were analyzed as part of the Fall Prevention/Resident Safety Plan Program Evaluation. The DON also verified that the results of the monthly restraint care audits were not considered in the evaluation of the safety policy as it refers to the use of restraints. The DON acknowledged that there was no written record of a monthly analysis or a record of the annual evaluation of the policy that included what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

Record review of the Fall Prevention/Resident Safety Plan Program Evaluation with review of service from October 2015 - October 2016 and dated October 28, 2016 determined that an analysis of the restraining of residents by use of a physical device was not undertaken on a monthly basis; and that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee’s policy as part of this evaluation. A "summary of changes made over the past year with date of change" included "double number of residents on restorative care programs" with no documentation related to the use of restraints. There was no documentation of the changes and improvements required to minimize restraining. As part of the Fall

Prevention/Resident Safety Plan Program Evaluation, there was no a written record of an analysis of the restraining of residents by use of a physical device.

The licensee failed to complete an analysis of the restraining of residents by use of a physical device on a monthly basis; that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining; that the results of the analysis undertaken were considered in the evaluation; that the changes or improvements were promptly implemented; and that a written record of everything and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented was promptly prepared.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 113.]

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 an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation; that the results of the analysis undertaken under clause (a) are considered in the evaluation; that the changes or improvements under clause (b) are promptly implemented; and that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything.

There was no documented evidence of corrective action taken as part of the three medication incident reports reviewed.

The DON shared that follow up with the registered nursing staff member was done at the time of the incident and was a one on one conversation only. The DON acknowledged that there was nothing documented in terms of the correction action either on the medication incident report or as part of the risk management documentation for the three medication errors identified.

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

Review of the Professional Advisory Committee (PAC) Minutes documented a meeting dated April 2, 2017. The "Medication Incidents" section documented, "For last quarter Dec. to Feb 28: 9 incidents involved administration. Incident meeting today to review administration focus: distractions as a cause of omissions and strategies." There was no other documentation of the changes and improvements identified.

Record review of the "Medication Errors" in the Risk Management documentation in PCC listed 11 medication incidents between December 2016 and February 28, 2017.

The DON acknowledged that not all 11 medication errors were reviewed during the April PAC meeting. The DON shared that strategies were discussed with pharmacy and there were changes made, but verified that there was no written record of the changes and improvements that were discussed as part of the quarterly review.

The licensee has failed to ensure that a quarterly review was undertaken of all 11 medication incidents and adverse drug reactions that have occurred in the home since the time of the last review and any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record was kept of everything, and to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

The licensee failed to ensure that training shall be provided to all staff who provide direct care to residents for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

Record review of the PASD/Restraint education between April - June 2016 documented the training material presented consisted only of information related to bed rails and entrapment.

The DON verified that education and training provided related to restraints was only about the use of bed rails, and that there was no training provided to direct care staff related to the application, use or potential dangers related to restraints by physical device or PASDs. The DON acknowledged that physical devices were used in the home other than bed rails, like lap trays, seat belts and tilt mechanisms on wheelchairs.

The licensee failed to train direct care staff in the application, use and potential dangers of physical devices and PASDs.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 11, 2015 as a Written Notification (WN) in the RQI #2015_355588_0015. [s. 221. (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 training shall be provided to all staff who provide direct care to residents for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

The licensee failed to ensure that the drug destruction and disposal policy provided for the following: that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

Record review of the Medical Pharmacies "Patch Disposal for Monitored Medication" policy 6-8 stated, "to standardize and allow safe and secure disposal of monitored (Narcotic & Controlled) medication dispensed as patches." The procedure stated, "Keep the 'Patch Disposal Record Sheet' and used patches in a zip lock bag in the double locked narcotic cabinet in the medication cart until the nurse has completed the medication pass."

Multiple Fentanyl patches for destruction applied to the "Patch Disposal Record Sheet" and stored in the locked controlled substances bin within the medication cart was observed during a shift change narcotic count.

Two Registered Practical Nurses (RPNs) stated that the "Patch Disposal Record Sheet" would be placed in the locked bin in the medication cart until the sheet was full and that could take several days. The RPNs verified that the locked bin in the medication cart stored controlled substances for administration.

The Director of Nursing (DON) acknowledged that the home policy instructs registered staff to place used narcotic patches in a zip lock bag and stored in the locked narcotic bin in the medication cart until the registered nursing staff have the opportunity for disposal.

The licensee failed to ensure that the drug destruction and disposal policy related to the disposal and destruction of narcotic and controlled medication dispensed as patches was stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home during a previous inspection in the last three years. [s. 136. (2) 2.]

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

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Issued on this 19th day of June, 2017

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) :	MELANIE NORTHEY (563), DONNA TIERNEY (569)
Inspection No. / No de l'inspection :	2017_606563_0009
Log No. / Registre no:	009951-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 9, 2017
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 ON MARY BUCKE 4 MARY BUCKE STREET, ST. THOMAS, ON, N5R-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kori Amon

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: 2016_326569_0005, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must achieve compliance to ensure that the home's policy "Pain Assessment" is complied with.

Specifically, the licensee will:
a) Ensure a Pain Assessment is completed when:
- a resident's pain is not relieved by initial interventions
- 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,
- a resident has new or worsening pain or if a resident indicates pain is present, and
- a resident who scores a two or higher on any RAI MDS assessment under section J2 2.

b) Ensure the Pain Assessment policy is evaluated and updated.
c) Ensure that all direct care staff receive education related to the Pain Assessment policy.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure,

strategy or system instituted or otherwise put in place was complied with.

The Resident Quality Inspection (RQI) #2016_326569_0005 Compliance Order (CO) #001 with a compliance date of April 18, 2016 stated the following:

The licensee must take immediate action to achieve compliance with O.Reg79/10, s.8. (1) (b).
The licensee must ensure that the home's policy "Pain Assessment" is complied with, including but not limited to the following:
1. For any resident who scores a two or higher on any RAI MDS assessment under section J2
2. When a resident indicates pain is present.
The home must also ensure that all direct care staff receive education related to the policy.

The "Pain Assessment" policy last revised May 2015 stated the following:
"1. Caressant Care recognizes the RAI MDS as a comprehensive assessment. 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 (see Appendix A). This assessment will also be utilized when: a new 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."

A) Record review of a "Pain" progress note in PointClickCare (PCC) stated a resident showed increased signs of discomfort.

The current care plan for the resident stated the resident had actual pain.

The "CC Pain Assessment Tool" in PCC was not completed related to the resident's discomfort as documented in the pain progress note.

Review of the Minimum Data Set (MDS) assessment section J2 documented there was an increase in the resident's pain from the previous quarterly assessment. There was no pain assessment completed until one month later.

There was no documented evidence in the resident's clinical record that a Pain Management Flow Sheet (PMFS) was completed when the resident experienced obvious discomfort with physical signs of pain.

B) Record review of the "Pain" progress note stated a resident displayed behaviours and admitted to having generalized discomfort with only some effect noted after the administration of a pain medication.

The current care plan for the resident stated the resident had specific pain.

The "CC Pain Assessment Tool" in PCC was not completed for the resident since admission.

The Resident Assessment Instrument Coordinator (RAI-C) shared that if the MDS section J2 documented a pain score of 2 or greater, then the resident's name would be added to a schedule for completion and that the registered staff were to refer to this schedule posted in the medication room and nursing office. The RAI-C shared that the pain assessment would also be completed with the onset of new pain or when new pain medication was started.

There was no documented evidence in the resident's clinical record that a Pain Management Flow Sheet (PMFS) was completed when the resident experienced generalized discomfort with only some effect noted after the administration of a pain medication.

The Registered Practical Nurse (RPN), the Registered Nurse (RN) and the Director of Nursing (DON) verified that the Pain Management Flow Sheet (PMFS) was no longer used by any registered staff, and a pain or vital sign progress note was now completed instead.

The DON acknowledged that a pain assessment was to be completed in PCC according to the home's policy.

C) Review of the staff sign in sheet related to the pain education in March 2016 documented that of the 11 registered staff members, three did not receive the

education related to the pain assessment policy. Also, of the 36 Personal Support Workers (PSW), six PSWs did not receive the education.

The DON shared that the "Pain Assessment" policy was read to the direct care staff at shift change during the month of March 2016. The DON shared that direct care staff also completed the "Pain Management Test" after the education session. The DON acknowledged that three registered staff and six PSWs did not receive the education related to the pain policy. The DON verified that education related to pain has not yet been completed for 2017.

The licensee failed to ensure that the Pain Assessment policy was complied with for these two residents and the licensee failed to ensure that all direct care staff received education related to the Pain Assessment policy.

The severity was determined to be a level 1 as there was minimal risk to residents. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 16, 2016 as a Compliance Order (CO) in the Resident Quality Inspection (RQI) #2016_326569_0005, issued on April 13, 2016 with a compliance date of April 18, 2016, and issued on June 11, 2015 as a Written Notification (WN) in the RQI #2015_355588_0015. [s. 8. (1) (b)] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 9th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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