Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Nov 26, 2015	2015_416515_0030	027944-15	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RAE MARTIN (515), HELENE DESABRAIS (615), NANCY JOHNSON (538), RUTH HILDEBRAND (128)

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): October 19-23, October 26-30 and November 2, 2015.

This Resident Quality Inspection was done in conjunction with a Complaint Inspection, Log # 027596-15 related to falls and alleged abuse/neglect; a Complaint Inspection , Log # 025756-15 related to laundry and reporting and complaints; and a Critical Incident Log # 029638-15 related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Maintenance Supervisor, Corporate Environmental Services Consultant, Resident Care Coordinator (RCC), Activity Coordinator, Maintenance Worker, five Registered Nurses (RN), nine Registered Practical Nurses (RPN), five Nurse's Aides (NA), two Health Care Aides (HCA), 15 Personal Support Workers (PSW), three Ward Clerks (WC), a Dietary Aide/Cook (DA), an Activity Aide, two Housekeeping Aides, three family members and 40+ Residents.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident-staff interactions, dining service, medication administration, medication storage areas, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, as well as the home's internal investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

A review of the home's "Ministry of Health Concerns" binder, revealed an identified resident had brought forth a concern.

The Administrator and the Director of Nursing acknowledged that they were aware of the incident, and confirmed that the incident was not reported to the Director. [s. 24. (1)]

2. A review of the Complaints Log revealed that a resident's family member submitted a written concern.

A review of the clinical record for the identified resident, revealed documentation indicated the resident was treated for an injury.

In an interview, the Director of Nursing and the Administrator acknowledged that they were aware of the incident and confirmed that they did not report the incident to the Ministry of Health and Long-Term Care.

The Administrator confirmed that the expectation was that a person who had reasonable grounds to suspect that abuse of a resident by anyone resulting in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the Falls Prevention program, that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A record review of the home's Falls Prevention program revealed there was no documented evidence of a written description of the program, that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Staff interview with the Resident Care Coordinator/Falls Prevention program Lead was unable to produce a falls program description, and confirmed that the home does not have a Falls Prevention program description.

The Director of Nursing (DON) confirmed that it was the expectation of the home that a Falls Prevention program description be completed. [s. 30. (1) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and ensure that a documented record was kept in the home.

Interview with an identified resident revealed that the resident made a complaint to a registered staff member about identified care issues.

Interview with the registered staff member revealed that the same day, the staff member informed the Director of Nursing in writing of the complaint.

Interview with the Director of Nursing and the Administrator revealed that the DON acknowledged receiving documentation from the registered staff member, misplaced the information and requested the information to be resubmitted. One week later, the DON received the requested documentation, investigated the incident and reported the incident to the Ministry of Health and Long-Term Care.

The DON and the Administrator both confirmed they were aware that the document was related to a resident complaint, but they were unaware what the complaint was regarding prior to the information being resubmitted.

Review of the home's "Ministry of Health Concerns" log revealed there was no documented record to support that an investigation was initiated immediately, or that a response was provided to the resident about what was done to resolve the complaint. The Administrator and the DON confirmed that the complaint was not investigated immediately.

The Administrator confirmed the home's expectation was every written or verbal complaint concerning the care of a resident was to be investigated immediately, a response provided to the complainant and a documented record was to be kept in the home. [s. 101.]

2. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

A review of the complaint logs revealed that a resident's family member had concerns regarding identified care issues.

A review of the home's internal records revealed there was no documented evidence that an investigation had been completed.

During an interview, the DON verified there was no follow-up done with the staff member.

In an interview, the Administrator confirmed the expectation was that where the complaint alleged harm or risk of harm to one or more residents, the investigation should have commenced immediately. [s. 101. (1) 1.]

3. The licensee has failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A review of the home's complaint logs for the calendar year 2015, revealed there were 27 resident complaints documented in 10 months.

There was no documented evidence of a final resolution for 11/27 (41 per cent) of the complaints.

There was no documented evidence of every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant for 27/27 (100 per cent) of the complaints.

In an interview, the Administrator acknowledged that the complaint logs did not contain information in accordance with the legislation and confirmed the expectation that the documented record in the home should include all the required information. [s. 101. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

A review of the policy entitled Preventative Maintenance Program for Resident's Rooms/Common Areas" effective January 2015, and reviewed August 2015, stated “On a quarterly basis, the Administrator and/or maintenance staff will inspect every room."

A review of the Preventative Maintenance Program revealed that there was no documented evidence that every room was inspected on a quarterly basis according to the policy.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies throughout the home:

Doors, door frames and wall surfaces observed to have paint scrapes and damage, damage to front facing of nurse’s station, loose flooring tiles, damaged thermostat cover, stained and damaged ceiling tiles, ceiling light burned out, missing pieces of baseboard and hand rail; damaged and stained wallpaper, stained and rusted baseboards, sharp window ledges, heat registers visibly rusted and pulled away from the wall, dead insects in ceiling lights and resident bathrooms noted to have rust on grab bars, dust build up in ceiling vents and stained caulking at the base of toilets.

During a tour and interview with the Maintenance Supervisor and the Administrator, the identified deficiencies were confirmed.

In an interview with the Administrator and the Maintenance Supervisor, they both acknowledged that every room had not been inspected quarterly.

In an interview with the Administrator and the Corporate Environmental Services Consultant, they acknowledged that the Preventative Maintenance program was not fully implemented and confirmed the home’s expectation was that there should be schedules in place for routine, preventative and remedial maintenance and that the preventative maintenance program should be implemented. [s. 90. (1) (b)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment.

On October 30, 2015, at approximately 0840 hours, the fire alarm sounded, a code red was called and approximately 15 staff responded to the lower level entrance area to receive instruction from the Administrator. A short time later, the Administrator directed staff to return to their resident areas.

While fire bells continued to ring, at approximately 0846 hours, two inspectors observed that the Stairwell #1 door leading to an identified resident home area was unlocked and no staff were observed to be monitoring the door. Resident's were still on the home area during the fire alarm and the elevator was not in service at the time. This observation was confirmed by the Administrator.

In an interview, the Administrator indicated that stairwell doors were equipped with magnetic locks that are disarmed during a fire alarm. The Administrator confirmed that a staff member should have been stationed at the door while the magnetic log was disarmed to ensure residents were safe and secure. [s. 5.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with the Act.

A review of the home's policy entitled Response to Complaints, dated February 2014, revealed the procedure directed staff that " If a complaint is received in writing, it must be forwarded to the facility's compliance advisor and a written response go back to the complainant."

The Regional Manager confirmed that the policy was presently in use and acknowledged that the procedure was not written in accordance with the legislation as the Ministry of Health and Long-Term Care has not had compliance advisors since July 2010.

The Regional Manager confirmed the expectation that any required plan, policy, protocol, procedure, strategy or system should be in compliance with and implemented in accordance with the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Record review of the home's policy and procedure "Lost Clothing" dated February 2013, indicated when lost clothing is reported to the nursing department, staff are to "notify laundry of the lost article(s), and give a clear description if available; check unmarked clothing cart to locate item(s); post a notice at the desk of item(s) missing so staff are aware.

Record review of the home's policy and procedure "Lost Clothing System" dated February 2013, indicated "if any resident clothing item cannot be identified as per Lost Clothing policy, the lost clothing system is to be initiated; unidentified clothing is either hung or placed in the laundry basket for month one; at the end of the first month, month one clothing is moved to the month two section and so on; at the end of month three, the clothing will be either distributed to needing residents and/or a charity. NOTE: The lost laundry rack should be placed on the floor for resident and family viewing twice a month."

Interviews with three residents revealed that all of the residents have had laundry go missing and that they were never found.

Staff interview confirmed that a lost laundry rack was not placed on the floor for resident and family viewing twice a month as per the home's procedures.

An interview with the Administrator confirmed that the home's policy and procedure for missing laundry was not implemented. It was the expectation of the home that required policies should be complied with. [s. 8. (1) (b)]

3. The licensee has failed to ensure that housekeeping policies to keep the home clean and sanitary were complied with.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies in housekeeping:

In resident bathrooms noted a wall visibly stained with urine, brown/yellow substance around the base of toilets, bathroom floor tiles had a build-up of black debris/dirt, toilet rims with mounted Versa frames visibly soiled with green/black/white substances behind the toilet seat, rust stains in toilet bowls, falls mats noted to have dust and dried spills, a resident's lounge chair was visibly soiled with a white substance on the arms of the chair and debris on the seat cushion and dried food on the walls of a dining room.

During a tour and interview with the Maintenance Supervisor and the Administrator, the identified deficiencies were confirmed, as well as the expectation that the home was to be kept clean and sanitary.

A review of the home's policy entitled Cleaning Guidelines – Common/General Areas, dated February, 2013, stated that in dining rooms "ensure all wall areas are clean. There must be no evidence of food staining the walls".
A review of the home's policy entitled Cleaning Guidelines – Resident Rooms, dated February 2013, stated the residents' room including washroom shall be thoroughly cleaned and monitored for safety hazards daily.

In an interview, the Maintenance Supervisor and the Administrator confirmed that the home was to be kept clean and sanitary and that the home's expectation was that housekeeping policies should be complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, is in compliance with and is implemented in accordance with applicable requirements under the Act, and is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 33. (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 a Personal Assistance Services Device (PASD) that was used to assist a resident with a routine activity of living was included in the resident's plan of care.

An identified resident was observed daily throughout the RQI to use an assistive device. Staff confirmed the observations and acknowledged that the resident used a PASD.

A review of the resident's clinical record revealed there was no documented evidence in the plan of care that the resident used an identified PASD.

In an interview, the Director of Nursing confirmed that it was the home's expectation that the PASD used to assist the resident with a routine activity of living should be included in the resident's plan of care. [s. 33. (3)]

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 be included in the resident's plan of care only when all of the following were 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. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD was 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. 4. The use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provided for everything required under subsection (5). 2007, c. 8, s. 33 (3).

Observations of an identified resident on three days revealed the resident used an identified assistive device.

Record review of the plan of care revealed documentation that the identified resident used an assistive device.

Staff interview with a Registered Nurse (RN), revealed that the resident used a PASD. The RN revealed that alternatives were not tried, where appropriate to assist the resident with the routine of daily living. There was no consent obtained from the substitute decision maker (SDM) and there was no approval from a clinical team member in accordance with the legislation.

Staff interview with the Director of Nursing confirmed that it was the home's expectation that alternatives were tried where appropriate to assist the resident with the routine of daily living, consent was obtained from the substitute decision maker when the resident

was incapable, and approval for the use of the PASD by an authorized member of the clinical team was required. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a Personal Assistance Services Device (PASD)is used to assist a resident with a routine activity of living, it is used only if the use of the PASD is included in the resident's plan of care. 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. 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. 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. 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. 5. The plan of care provides for everything required under subsection (5), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review of the progress notes for a three month period revealed that an identified resident was assessed as a high risk for falling and had sustained three falls on three identified dates. There was no documented evidence that a post-fall risk assessment was completed by a registered staff for those dates.

The Director of Nursing confirmed the lack of the post fall assessment and stated that it was the home's expectation that when a resident sustained a fall, the resident was assessed and, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council had advised the licensee of concerns or recommendations, the licensee, within 10 days of receiving the advice, responded to the Family Council in writing.

In an interview with a member of the Family Council, it was revealed that the Administrator does not respond to all of the concerns identified in the meeting minutes.

A review of the Family Council meeting minutes for four identified dates and corresponding responses from the Administrator revealed that one of four (25 per cent) of the responses were not received within 10 days and 20 to 66 per cent of the identified concerns were not addressed in the correspondence back to the Family Council.

In an interview, the Administrator indicated that in instances where information was forwarded to Head Office, and a response was required to address the concern, the response was not always returned within 10 days. In these cases, the Administrator acknowledged that the concern was not mentioned in the written response to the Family Council and in future it would be best to report that Head Office had been notified and the home was awaiting a response.

The Administrator confirmed the expectation that the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. [s. 60. (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 if the Family Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information, including minutes of the most recent Residents' Council meetings, was posted in the home.

Observation on October 19, 2015, revealed no evidence of the Residents' Council meeting minutes posted in the home.

Staff interview with a personal support worker and the Activity Coordinator confirmed that the Resident's Council minutes were not posted.

An interview with the Administrator confirmed that it was the expectation of the home that the minutes of the Residents' Council meetings be posted in the home. [s. 79. (3) (n)]

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 most recent minutes of the Residents' Council meetings are posted, with the consent of the Residents' Council, to be implemented voluntarily.

Issued on this 30th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RAE MARTIN (515), HELENE DESABRAIS (615), NANCY JOHNSON (538), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_416515_0030
Log No. / Registre no:	027944-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 26, 2015
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 WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA VAN QUAETHEM

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must take action to achieve compliance by:

a) Reviewing the established process for reporting suspected resident abuse;
b) Ensuring all staff have received annual training in Mandatory reporting requirements; and
c) Developing and implementing a system to track the reported incidents to enable monitoring of time lines for submission to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

A review of the Complaints Log revealed that a resident's family member submitted a written concern.

A review of the clinical record for the identified resident, revealed documentation indicated the resident was treated for an injury.

In an interview, the Director of Nursing and the Administrator acknowledged that they were aware of the incident and confirmed that they did not report the incident to the Ministry of Health and Long-Term Care.

The Administrator confirmed that the expectation was that a person who had reasonable grounds to suspect that abuse of a resident by anyone resulting in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)] (515)

2. A review of the home's "Ministry of Health Concerns" binder, revealed an identified resident had brought forth a concern.

The Administrator and the Director of Nursing acknowledged that they were aware of the incident, and confirmed that the incident was not reported to the Director. [s. 24. (1)] (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must develop a written description for the Falls Prevention program that includes the following:

a) goals and objectives;
b) relevant policies, procedures and protocols; and
c) methods to reduce risk and monitor outcomes including protocols for the referral of residents to specialized resources where required.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written description of the Falls Prevention program, that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A record review of the home's Falls Prevention program revealed there was no documented evidence of a written description of the program, that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Staff interview with the Resident Care Coordinator/Falls Prevention program Lead was unable to produce a falls program description, and confirmed that the home does not have a Falls Prevention program description.

The Director of Nursing (DON) confirmed that it was the expectation of the home that a Falls Prevention program description be completed. [s. 30. (1) 1.] (538)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee must take action to achieve compliance by:

1. Ensuring the process for dealing with complaints includes the following:
a) investigating the complaint and resolving where possible;
b) providing a response within 10 business days of receipt of the complaint;
c) where the complaint alleges harm or risk of harm to one or more residents, the investigation is started immediately.

2. Ensuring that a documented record is kept of all complaints lodged with the licensee. The documented record must include:
a) The final resolution, if any;
b) Every date on which any response was provided to the complainant and a description of the response; and
c) Any response made in turn by the complainant.

Grounds / Motifs :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and ensure that a documented record was kept in the home.

Interview with an identified resident revealed that the resident made a complaint to a registered staff member about identified care issues.

Interview with the registered staff member revealed that the same day, the staff member informed the Director of Nursing in writing of the complaint.

Interview with the Director of Nursing and the Administrator revealed that the DON acknowledged receiving documentation from the registered staff member, misplaced the information and requested the information to be resubmitted. One week later, the DON received the requested documentation, investigated the incident and reported the incident to the Ministry of Health and Long-Term Care.

The DON and the Administrator both confirmed they were aware that the document was related to a resident complaint, but they were unaware what the complaint was regarding prior to the information being resubmitted.

Review of the home's "Ministry of Health Concerns" log revealed there was no documented record to support that an investigation was initiated immediately, or that a response was provided to the resident about what was done to resolve the complaint. The Administrator and the DON confirmed that the complaint was not investigated immediately.

The Administrator confirmed the home's expectation was every written or verbal complaint concerning the care of a resident was to be investigated immediately, a response provided to the complainant and a documented record was to be kept in the home. [s. 101.] (615)

2. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

A review of the complaint logs revealed that a resident's family member had concerns regarding identified care issues.

A review of the home's internal records revealed there was no documented evidence that an investigation had been completed.

During an interview, the DON verified there was no follow-up done with the staff member.

In an interview, the Administrator confirmed the expectation was that where the

complaint alleged harm or risk of harm to one or more residents, the investigation should have commenced immediately. [s. 101. (1) 1.] (515)

3. The licensee has failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A review of the home's complaint logs for the calendar year 2015, revealed there were 27 resident complaints documented in 10 months.

There was no documented evidence of a final resolution for 11/27 (41 per cent) of the complaints.

There was no documented evidence of every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant for 27/27 (100 per cent) of the complaints.

In an interview, the Administrator acknowledged that the complaint logs did not contain information in accordance with the legislation and confirmed the expectation that the documented record in the home should include all the required information. [s. 101. (2)] (515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must take action to achieve compliance by:

a) Implementing their Preventative Maintenance program to ensure schedules are in place for routine, preventative and remedial maintenance;
b) Ensuring that maintenance inspections are completed and documented in accordance with the home's policy; and
c) Ensuring an action plan based on the identified deficiencies is documented, monitored and evaluated for completion.

Grounds / Motifs :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

A review of the policy entitled Preventative Maintenance Program for Resident's Rooms/Common Areas" effective January 2015, and reviewed August 2015, stated “On a quarterly basis, the Administrator and/or maintenance staff will inspect every room."

A review of the Preventative Maintenance Program revealed that there was no documented evidence that every room was inspected on a quarterly basis according to the policy.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies throughout the home:

Doors, door frames and wall surfaces observed to have paint scrapes and damage, damage to front facing of nurse's station, loose flooring tiles, damaged thermostat cover, stained and damaged ceiling tiles, ceiling light burned out, missing pieces of baseboard and hand rail; damaged and stained wallpaper, stained and rusted baseboards, sharp window ledges, heat registers visibly rusted and pulled away from the wall, dead insects in ceiling lights and resident bathrooms noted to have rust on grab bars, dust build up in ceiling vents and stained caulking at the base of toilets.

During a tour and interview with the Maintenance Supervisor and the Administrator, the identified deficiencies were confirmed.

In an interview with the Administrator and the Maintenance Supervisor, they both acknowledged that every room had not been inspected quarterly.

In an interview with the Administrator and the Corporate Environmental Services Consultant, they acknowledged that the Preventative Maintenance program was not fully implemented and confirmed the home's expectation was that there should be schedules in place for routine, preventative and remedial maintenance and that the preventative maintenance program should be implemented. [s. 90. (1) (b)] (515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rae Martin

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