Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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 Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2019	2019_722630_0006 (A2)	009996-18, 015131-18, 025670-18, 025752-18, 026289-18, 026327-18, 029921-18, 002315-19, 005210-19	Critical Incident System

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

Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee has requested and Ministry approves an extension to the compliance due date of October 31, 2019 to November 30, 2019. This extension will allow the home to complete sustainable education regarding the Behavioural Supports Ontario (BSO) program in the home and effective auditing.

Issued on this 18th day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 25, 26, 28, March 1, 4, 5, 6, 7, 8, 11, 12, 13, 14 and 18, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention

Critical Incident Log #026289-18 / CI 2636-000052-18

Critical Incident Log #029921-18 / CI 2636-000071-18

Critical Incident Log #002315-19 / CI 2636-000009-19

Critical Incident Log #005210-19 / CI 2636-000017-19

Related to the prevention of resident to resident abuse and responsive behaviours:

Critical Incident Log #009996-18 / CI 2636-000022-18

Critical Incident Log #015131-18 / CI 2636-000025-18

Critical Incident Log #025670-18 / CI 2636-000045-18

Critical Incident Log #025752-18 / CI 2636-000048-18

Critical Incident Log #026327-18 / CI 2636-000053-18

Documentation of non-compliance related to Critical Incident Log #026289-18 and Critical Incident Log #005210-19 can be found in the Inspection Report for

Follow-Up Inspection #2019_722630_0005.

During the course of the inspection, the inspector(s) spoke with the Caressant Care Director of Operations, the Caressant Care Director of Quality and Privacy, the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), a Resident Care Coordinator (RCC), a Resident Assessment Instrument (RAI) Co-ordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO Personal Support Workers (PSW), Registered Nurses (RN), RPNs, PSWs, and residents.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed various meeting minutes, reviewed written records of program evaluations and also reviewed the Caressant Care Woodstock Plan of Corrective Action.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

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

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the matters referred to in subsection 53 (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and that a written record was kept relating to each evaluation that included 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.

Ontario Regulation 79/10 s. 53 (1) states "every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional,

social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required."

Specifically, based on interviews and record reviews, the licensee has failed to ensure that the annual evaluation of the responsive behaviours program for the home included an evaluation of all matters identified in s 53 (1) and included a record of all required information in s 53 (3)(c).

The home's policy titled "Policy and Procedure for Program Evaluation" last reviewed on an identified date, included the following:
- "pertinent information will be documented including but not limited to; who participates in the review, any changes made to the program and the date the changes took place."
- "each department manager is responsible for assembling a team to collect the data. The review team members should have knowledge of the service provided and be able to offer input."
- "when the information is complete, it is to be brought to the Quality Improvement committee and reviewed with all committee members to analyze and identify improvement opportunities."
- "the analysis of the programs and improvements made, will be communicated to the Residents Council, Family Council and the staff on an on-going basis. Evidence of this communication should be included in the notes on each evaluation."

A document titled "Quality Program Evaluation Responsive Behaviours" was provided to Inspector #745 by a staff member. This document identified that the review had been completed by one specific staff member, which covered an identified date range. This written record did not identify implementation dates for the "List of Responsive Behaviour Program Goals for the Next Year". The record did not identify dates for trends observed or changes made over the past year. The record also did not include documentation of the changes that were made and the date these changes were implemented in the "List Actions/Areas for Improvement" item. The record did not identify the committee members or the members present for the evaluation.

During an interview with the specific staff member who was listed on the evaluation document, they said they were not involved in completing the "Quality

Program Evaluation" for the responsive behaviours program on an identified date and that they had never seen this evaluation before the interview.

A second document titled "Quality Program Evaluation Responsive Behaviours" was provided on another date to Inspector #745 by a staff member. The document identified that this review was completed by two specific staff members on an identified date. This evaluation had several sections that had no documentation completed, that included the following: "List the dates of the responsive behaviour meetings held in the home"; "Quality indicators, previous and current year"; "% of residents with worsening behavioural symptoms"; "% of residents with improved behaviour symptoms"; "Were program objectives met"; "Program evaluation discussed (committee and date)"; and "if needed, has an action plan been developed". It failed to include documentation of the changes that were made and the date these changes were implemented in the "list actions/areas for improvement" section. It also did not include procedures, identify dates for trends observed or changes made over the past year.

During an interview with one of the specific staff members listed on the second evaluation document, they said they did not usually complete quality program evaluations, but they had been assisting the home. They said they did remember completing quality program evaluation for responsive behaviours for an identified date. They said they set the list of program goals from their practices and experience at other homes. They said areas for improvement were identified by looking at other homes and what they did. They said no other staff were consulted or present to complete this evaluation. This staff member said they did not know why there were two evaluations forms with different review of service dates. They did not recall seeing the evaluation on an identified date, prior to the interview and they could not identify the writing. The staff member said they did not know if staff had been educated to the new program goals.

Based on these interviews and the review of the written records the licensee has failed to ensure that at least annually, the matters referred to in subsection 53 (1) were evaluated and updated in accordance with evidence-based practices and the annual evaluations on identified dates, did not accurately identify the names of persons who participated in the evaluation. The written records of the evaluation did not include a summary of changes made and the date the changes were implemented. (745) [s. 53. (3)]

2. The licensee has failed to ensure that for each resident who demonstrated

responsive behaviours, (a) the behavioural triggers for the resident were identified where possible, (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions, and that the resident's responses to interventions were documented.

A) The home submitted several Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to the responsive behaviours for an identified resident.

The clinical record for this identified resident included progress notes which documented that the resident had specific responsive behaviours on specific dates. A Responsive Behaviour Tracking Record for this resident showed they had specific responsive behaviours on specific shifts. Inspector #730 was unable to locate other tracking records that had been completed for this resident. There was a "Responsive Behaviours Potential Triggers – Checklist" in the resident's paper chart with a specified date which was not completed. There was an assessment titled "CC PIECES Assessment Worksheet" and this assessment did not appear to be completed. Inspector #730 was not able to locate Dementia Observation System (DOS) charting for this resident. The plan of care included responsive behaviours, however there were no potential triggers identified for the resident's responsive behaviours and not all of this resident's known responsive behaviours were included.

The home's policy titled "Resident Behaviour Management" reviewed on a specified date, included the following procedures:
- "1. If a resident is exhibiting a behaviour that is identified by staff to be disruptive or potentially injurious to the resident or others, a responsive behaviour tracking record will be initiated and completed over 72 hours, the flow sheet will be given to the charge nurse to be assessed."
- "4. The multidisciplinary team will also completed the Responsive Behaviour Checklist for Potential Triggers, this will allow the team to identify the potential triggers and create the correct interventions. For residents with known behaviours please completed the checklist and include the triggers on the care plan."
- "5. Using a multidisciplinary team the care plan will be updated to include what the behaviours are, known triggers and interventions."

During an interview with a specific staff member they told Inspector #730 they had been familiar with this resident and the resident had a lot of responsive

behaviours. The staff member said that they were familiar with the use of the Responsive Behaviours Potential Triggers- Checklist" in the home and there should have been one completed by registered staff for this resident. The staff member said they were familiar with the responsive behaviour tracking record as they had sometimes seen them for admissions but there seemed to have been some confusion about those forms. The staff member said they were not sure of the triggers for this resident's behaviours. When asked what interventions were in place to deal with the resident's responsive behaviours, the staff member said the interventions that were in place did not seem effective.

During an interview the Assistant Director of Care (ADOC) told Inspector #730 that the home was aware of this resident's responsive behaviours on a specified date after a specific incident had occurred. The ADOC stated that the "Responsive Behaviours Potential Triggers- Checklist" was to be completed on admission and when asked if this assessment was completed on admission for this resident they stated 'no.' The ADOC said that the "Behaviour Tracking Record" should be completed after a new behaviour or incident occurred. Inspector #730 told the ADOC that they were not able to locate "Responsive Behaviour Tracking Records" except upon admission, and the ADOC stated that if those records were not included in the resident's paper chart they were most likely not completed, and they should have been completed. The ADOC acknowledged that the "CC PIECES Assessment Worksheet" for this resident was not completed. They stated that Dementia Observation System (DOS) charting should be completed after a resident to resident physical altercation. The ADOC stated that details related to the resident's responsive behaviours would be documented in the care plan. The ADOC stated that there were no triggers documented in this resident's care plan on a specified date.

Based on these interviews and record reviews this identified resident demonstrated frequent responsive behaviours. Although strategies had been initiated to identify triggers and respond to the behaviours, the actions taken within the home to meet the needs of this resident related to responsive behaviours did not include documented assessments or reassessments, the identification of triggers in the plan of care, the consistent implementation of interventions or documentation of the effectiveness of the interventions. (730)

B) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, related to a altercation between two identified residents which resulted in a specific injury to

one of the residents.

During an interview with a specific staff member, they stated that they documented information related to responsive behaviours in the care plan, in an admission progress note or in the kardex, however it was not documented in one consistent place. This staff member acknowledged that they needed to be more consistent so that staff could find information. They stated that a lot of the information was not documented and that they had not received a lot of guidance with their role in the home. This staff member stated they were familiar with this resident and they followed them in the specified program. This staff member told Inspector #745 that they were not able to find any documented assessments for this resident related to responsive behaviours.

Inspector #745 reviewed the current "BSO Caseload and Discharge Record" and this resident was not on the list.

The clinical record for this resident included progress notes which documented specific responsive behaviours on specific dates. The "Assessments" section in the electronic documentation system included a "CC Pieces assessment worksheet" which was not completed. The paper clinical record had a "Responsive Behaviours Potential Triggers-Checklist" for this resident which was last updated 2017. A referral form to an external resource for a specific date identified that the responsive behaviours had been getting worse. No "Responsive Behaviour Tracking Records" were found in the resident's chart for any documented incidents of behaviours. The plan of care for this resident showed that the resident had responsive behaviours but the plan of care did not include the identification of triggers. The interventions in the plan of care were not changed or updated in care plans.

During an interview with a specific staff member, they said they had received no clear direction on using the "Responsive Behaviour Tracking Record". They said they thought it was just a form used on admission and they said it had not been used routinely. They said they had seen the "Responsive Behaviours Potential Triggers - Checklist" in admission packages, but was unsure who was responsible to fill it out and update it. They said they were not familiar with the "Resident Behaviour Management" policy and they did not use the "Responsive Behaviour Tracking Record" or assess the records as the charge nurse as per policy. They also said they are not familiar with the "Responsive Behaviours Decision Tree." The staff member said they were familiar with this identified resident and there

were specific interventions staff used for responsive behaviours. The staff member said this resident had been having ongoing behaviours, so definitely should have had updated assessments and they thought nothing had been updated.

During an interview with another staff member they stated they did not know who in the home was responsible for initiating the "Responsive Behaviours Triggers - Checklist" and they said they had never seen that form before and were not sure who updated it or how often it was to be updated. The staff member said they could not find any "Responsive Behaviours Tracking Records" for this resident for documented incidents of behaviours. They could not find any charting showing that triggers and interventions were updated after a specific incident. They said staff should have assessed this resident and put interventions in place as per the policy.

During an interview with the Director of Care (DOC), they said they were the lead for the responsive behaviour program in the home but had just recently started in that role. The DOC said staff were to use the "Responsive Behaviours Potential Triggers-Checklist" and "Responsive Behaviour Tracking Record" to update residents care plans. They said they did not have records that monitoring of responsive behaviours documentation had occurred as per the policy. They said they had not reviewed the behaviours policy or read it since starting work at the home. The DOC said they did not know how care plans were being updated if tracking tools were not being used.

Based on these interviews and record reviews this identified resident demonstrated frequent responsive behaviours prior to the Critical Incident and their behaviours escalated further after that incident. Although strategies had been initiated to identify triggers and respond to the behaviours, the actions taken within the home to meet the needs of this resident related to responsive behaviours did not include documented assessments or reassessments, the identification of triggers in the plan of care, the consistent implementation of interventions or documentation of the effectiveness of the interventions. (745)

C) The home submitted a Critical Incident System (CIS) report to the MOHLTC, related to physical altercations between two identified residents.

Observations by Inspector #745 during the inspection found this identified resident exhibited specific responsive behaviours.

During an interview with a staff member, they stated they were familiar with this resident and this resident did have responsive behaviours. The staff member said that there had not been a referral made to the BSO program in the home for this resident. During an interview with another staff member they said this resident had responsive behaviours. They said each shift the staff would document in mood and behaviours in Point of Care (POC) but was not aware if anything was done with that charting.

In an interview with another staff member they said they were familiar with this resident and this was a resident with responsive behaviours. The staff member said they thought responsive behaviours were documented each shift by staff in the electronic documentation system under mood and behaviours but they were not sure.

The clinical record for this identified resident included progress notes which showed this resident had specific responsive behaviours on specific dates. There was a "Responsive Behaviours Potential Triggers Checklist" in the hard copy chart dated 2017 with no other completed checklists since that time. No "Responsive Behaviour Tracking Records" were found for any documented incidents of behaviours. There were no documented assessments or reassessments of this resident's behaviours. The plan of care for this resident showed that the resident had responsive behaviours but the plan of care did not include triggers and interventions were not changed or updated in care plans.

During an interview with the Assistant Director of Care (ADOC) they said that nurses normally completed the "Responsive Behaviours Potential Triggers-Checklist" on admission and whenever there was a behaviour that was not normal. The ADOC said staff should monitor behaviours for three days after incident in a behaviour progress note and that DOS should also be completed.

Based on these interviews and record reviews, this identified resident was demonstrating frequent responsive behaviours. The strategies that were developed to identify triggers and respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented assessments or reassessments. (745) [s. 53. (4)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 002

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

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date. The CIS report stated that an identified resident fell, which resulted in a specific injury.

A Physiotherapy Fall/Post Fall Assessment progress note stated that a specific intervention was recommended to be used for this resident for safety, that the

nurse was aware and that a note was left in the Resident Care Coordinator (RCC)'s mailbox regarding the recommendation.

A review of the resident's plan of care by Inspector #730 found that it did not include this specific intervention.

During an interview with an identified staff member, when asked how they would know what interventions were in place for a resident in regards to falls prevention, they stated that they would look in the plan of care or the kardex. When asked what interventions were currently in place for this resident in regards to falls prevention, they stated that the resident used this specific intervention. The staff member and Inspector #730 reviewed the current kardex for this resident and the staff member acknowledged that it did not state in the resident's care plan that the resident used this intervention.

In an interview with a registered nursing staff member, when asked if this resident used this intervention they stated "no" as it would be in their plan of care if they used them.

During an interview with a Physiotherapist they stated that they had recommended this intervention for this resident after their fall on a specified date. They said that they were not sure if the intervention had been implemented because they had not spoken to the nurses about whether the resident was refusing them. They also said that they and the registered staff were responsible for updating plans of care in regards to interventions for falls prevention.

During an interview another staff member told Inspector #730 that this identified resident was not using that intervention that day due to refusal.

During an interview with another registered nursing staff member, they stated that there was some discrepancy about whether this resident was to be using this intervention.

The licensee has failed to ensure that the plan of care was revised when resident a resident's care needs changed related to falls prevention. (730) [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

The home submitted a Critical Incident System (CIS) report to the MOHLTC on a specified date. The CIS report stated that an identified resident sustained an injury related to a specific fall.

The plan of care for this resident included a specific intervention related to safe transferring and positioning.

The progress notes for this resident documented specific details about the fall including details related to transferring and positioning as well as the injury sustained.

In an interview with a staff member they stated that they were working when this resident had fallen. They stated that the resident required a specific type of intervention related to transferring and positioning.

Inspector #730 reviewed relevant employee files which described the incident as improper care/not following policy as the staff failed to provide the specific intervention included in the plan of care for safe transferring and positioning.

The licensee failed to ensure that staff used safe transferring and positioning devices and techniques for this identified resident. (730) [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1) (3) or (3.1), within 10 days of becoming aware of the incident the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a Critical System Incident (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date. The CIS report stated that this resident a fall within the documentation for the CIS report the question "What is the outcome/current status of the individual(s) who was/were involved in this occurrence?" the report did not include updated information regarding the status of the resident. The CIS report was not updated by the home to include further information regarding the status of the resident after the incident.

In an interview with a Resident Care Coordinator (RCC) and the Assistant Director of Care (ADOC), the RCC stated that this resident's fall on a specified date had resulted in a significant change in the resident's health status. The RCC acknowledged that the report was not updated to include the status of the resident and said it was their expectation that the CIS report would have been updated to include that information.

The licensee has failed to ensure that the Director was updated with the outcome or current status of an individual involved in an incident under subsection (1) (3) or (3.1) within 10 days. (730) [s. 107. (4) 3. v.]

Issued on this 18th day of October, 2019 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A2)
Inspection No. / No de l'inspection :	2019_722630_0006 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009996-18, 015131-18, 025670-18, 025752-18, 026289-18, 026327-18, 029921-18, 002315-19, 005210-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 18, 2019(A2)
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 :	Carol Bradley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (3) The licensee shall ensure that,

(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 53 (3) (b) and (c).

Specifically the licensee must:

a) Develop a documented procedure in the home to ensure that the evaluation of the Responsive Behaviours program required under 53 of the Regulations is completed in accordance with the legislation. This procedure must include the communication of the results of the evaluation to the staff of the home.

b) Complete a new program evaluation of the Responsive Behaviours program using the newly developed documented procedure in the home.

c) Ensure that the written record of Responsive Behaviours program evaluation includes:
i) the date the evaluation was completed;
ii) the full names and signatures of the persons who participated in the evaluation and the dates when they participated;
iii) a summary of the changes made to the program and the date that those changes were implemented;
iv) the dates of the responsive behaviour meetings held in the home and who attended.

d) The evaluation of the program and improvements made must be communicated to the leadership team in the home, including the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC) and the Resident Care Coordinators (RCC) as well as the Behavioural Supports Ontario (BSO) team in the home including the Registered Practical Nurse (RPN) and Personal Support Workers (PSWs). The documented evidence of this communication must be included in the notes on the written record of the program evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that at least annually, the matters referred to in subsection 53 (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and that a written record was kept relating to each evaluation that included 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.

Ontario Regulation 79/10 s. 53 (1) states "every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required."

Specifically, based on interviews and record reviews, the licensee has failed to ensure that the annual evaluation of the responsive behaviours program for the home included an evaluation of all matters identified in s 53 (1) and included a record of all required information in s 53 (3)(c).

The home's policy titled "Policy and Procedure for Program Evaluation" last reviewed on an identified date, included the following:
- "pertinent information will be documented including but not limited to; who participates in the review, any changes made to the program and the date the changes took place."
- "each department manager is responsible for assembling a team to collect the data. The review team members should have knowledge of the service provided and be able to offer input."
- "when the information is complete, it is to be brought to the Quality Improvement committee and reviewed with all committee members to analyze and identify improvement opportunities."
- "the analysis of the programs and improvements made, will be communicated to the Residents Council, Family Council and the staff on an on-going basis. Evidence of this communication should be included in the notes on each evaluation."

A document titled "Quality Program Evaluation Responsive Behaviours" was provided to Inspector #745 by a staff member. This document identified that the review had been completed by one specific staff member, which covered an identified date range. This written record did not identify implementation dates for the

"List of Responsive Behaviour Program Goals for the Next Year". The record did not identify dates for trends observed or changes made over the past year. The record also did not include documentation of the changes that were made and the date these changes were implemented in the "List Actions/Areas for Improvement" item. The record did not identify the committee members or the members present for the evaluation.

During an interview with the specific staff member who was listed on the evaluation document, they said they were not involved in completing the "Quality Program Evaluation" for the responsive behaviours program on an identified date and that they had never seen this evaluation before the interview.

A second document titled "Quality Program Evaluation Responsive Behaviours" was provided on another date to Inspector #745 by a staff member. The document identified that this review was completed by two specific staff members on an identified date. This evaluation had several sections that had no documentation completed, that included the following: "List the dates of the responsive behaviour meetings held in the home"; "Quality indicators, previous and current year"; "% of residents with worsening behavioural symptoms"; "% of residents with improved behaviour symptoms"; "Were program objectives met"; "Program evaluation discussed (committee and date)"; and "if needed, has an action plan been developed". It failed to include documentation of the changes that were made and the date these changes were implemented in the "list actions/areas for improvement" section. It also did not include procedures, identify dates for trends observed or changes made over the past year.

During an interview with one of the specific staff members listed on the second evaluation document, they said they did not usually complete quality program evaluations, but they had been assisting the home. They said they did remember completing quality program evaluation for responsive behaviours for an identified date. They said they set the list of program goals from their practices and experience at other homes. They said areas for improvement were identified by looking at other homes and what they did. They said no other staff were consulted or present to complete this evaluation. This staff member said they did not know why there were two evaluations forms with different review of service dates. They did not recall seeing the evaluation on an identified date, prior to the interview and they could not identify the writing. The staff member said they did not know if staff had been

educated to the new program goals.

Based on these interviews and the review of the written records the licensee has failed to ensure that at least annually, the matters referred to in subsection 53 (1) were evaluated and updated in accordance with evidence-based practices and the annual evaluations on identified dates, did not accurately identify the names of persons who participated in the evaluation. The written records of the evaluation did not include a summary of changes made and the date the changes were implemented. (745) [s. 53. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm. The scope of this issue was level 3 as it represented a systemic failure that had the potential to affect a large number of the LTCH's residents. The home has a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued May 24, 2017 (2016_229213_0039). (745)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 53 (4).

Specifically the licensee must ensure the following:

a) The home's policy titled Resident Behaviour Management is complied with for two identified residents and any other resident displaying responsive behaviours. This includes, but is not limited to:
i) investigating the causes of observed behaviours;
ii) conducting and documenting assessments of behaviours;
iii) ensuring the required information is contained in the resident's plan of care relating to triggers, detailed descriptions of behaviours and interventions.

b) Ensure all RNs, RPNs and PSWs are familiar with the plan of care for two identified residents and any other resident displaying responsive behaviours, related to their responsive behaviours and that staff are consistent in the application and implementation of these interventions.

c) Ensure there is a process in the home for documenting the effectiveness of the interventions related to responsive behaviours and this process is consistently implemented by staff in the home.

d) The home must ensure the Director of Care (DOC), Assistant Director of Care (ADOC), the Resident Care Coordinators (RCCs), all RAI-Co-ordinators, the BSO RPN and PSWs, all RPNs, RNs, including agency staff, are provided in-person training on the home's Resident Behaviour Management policy. The home must keep a documented record of the education provided including who provided the education, when it was provided, who completed the education and the materials that were covered during the education.

e) The home must develop and fully implement an auditing process to ensure the Resident Behaviour Management policy is being complied with by staff in the home. This auditing process must be documented including the auditing schedule, the names of the people conducting the audits, the residents who have been audited and when the audit was completed, the results of the audit and what was done with the results of the audit.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, (a) the behavioural triggers for the resident were identified where possible, (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions, and that the resident's responses to interventions were documented.

A) The home submitted several Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to the responsive behaviours for an identified resident.

The clinical record for this identified resident included progress notes which documented that the resident had specific responsive behaviours on specific dates. A Responsive Behaviour Tracking Record for this resident showed they had specific responsive behaviours on specific shifts. Inspector #730 was unable to locate other tracking records that had been completed for this resident. There was a "Responsive Behaviours Potential Triggers – Checklist" in the resident's paper chart with a specified date which was not completed. There was an assessment titled "CC PIECES Assessment Worksheet" and this assessment did not appear to be completed. Inspector #730 was not able to locate Dementia Observation System (DOS) charting for this resident. The plan of care included responsive behaviours, however there were no potential triggers identified for the resident's responsive behaviours and not all of this resident's known responsive behaviours were included.

The home's policy titled "Resident Behaviour Management" reviewed on a specified date, included the following procedures:
- "1. If a resident is exhibiting a behaviour that is identified by staff to be disruptive or potentially injurious to the resident or others, a responsive behaviour tracking record will be initiated and completed over 72 hours, the flow sheet will be given to the charge nurse to be assessed."
- "4. The multidisciplinary team will also completed the Responsive Behaviour Checklist for Potential Triggers, this will allow the team to identify the potential triggers and create the correct interventions. For residents with known behaviours please completed the checklist and include the triggers on the care plan."
- "5. Using a multidisciplinary team the care plan will be updated to include what the

behaviours are, known triggers and interventions."

During an interview with a specific staff member they told Inspector #730 they had been familiar with this resident and the resident had a lot of responsive behaviours. The staff member said that they were familiar with the use of the Responsive Behaviours Potential Triggers- Checklist" in the home and there should have been one completed by registered staff for this resident. The staff member said they were familiar with the responsive behaviour tracking record as they had sometimes seen them for admissions but there seemed to have been some confusion about those forms. The staff member said they were not sure of the triggers for this resident's behaviours. When asked what interventions were in place to deal with the resident's responsive behaviours, the staff member said the interventions that were in place did not seem effective.

During an interview the Assistant Director of Care (ADOC) told Inspector #730 that the home was aware of this resident's responsive behaviours on a specified date after a specific incident had occurred. The ADOC stated that the "Responsive Behaviours Potential Triggers- Checklist" was to be completed on admission and when asked if this assessment was completed on admission for this resident they stated 'no.' The ADOC said that the "Behaviour Tracking Record" should be completed after a new behaviour or incident occurred. Inspector #730 told the ADOC that they were not able to locate "Responsive Behaviour Tracking Records" except upon admission, and the ADOC stated that if those records were not included in the resident's paper chart they were most likely not completed, and they should have been completed. The ADOC acknowledged that the "CC PIECES Assessment Worksheet" for this resident was not completed. They stated that Dementia Observation System (DOS) charting should be completed after a resident to resident physical altercation. The ADOC stated that details related to the resident's responsive behaviours would be documented in the care plan. The ADOC stated that there were no triggers documented in this resident's care plan on a specified date.

Based on these interviews and record reviews this identified resident demonstrated frequent responsive behaviours. Although strategies had been initiated to identify triggers and respond to the behaviours, the actions taken within the home to meet the needs of this resident related to responsive behaviours did not include documented assessments or reassessments, the identification of triggers in the plan of care, the consistent implementation of interventions or documentation of the

effectiveness of the interventions. (730)

B) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, related to a altercation between two identified residents which resulted in a specific injury to one of the residents.

During an interview with a specific staff member, they stated that they documented information related to responsive behaviours in the care plan, in an admission progress note or in the kardex, however it was not documented in one consistent place. This staff member acknowledged that they needed to be more consistent so that staff could find information. They stated that a lot of the information was not documented and that they had not received a lot of guidance with their role in the home. This staff member stated they were familiar with this resident and they followed them in the specified program. This staff member told Inspector #745 that they were not able to find any documented assessments for this resident related to responsive behaviours.

Inspector #745 reviewed the current “BSO Caseload and Discharge Record” and this resident was not on the list.

The clinical record for this resident included progress notes which documented specific responsive behaviours on specific dates. The "Assessments" section in the electronic documentation system included a “CC Pieces assessment worksheet” which was not completed. The paper clinical record had a “Responsive Behaviours Potential Triggers-Checklist” for this resident which was last updated 2017. A referral form to an external resource for a specific date identified that the responsive behaviours had been getting worse. No “Responsive Behaviour Tracking Records” were found in the resident's chart for any documented incidents of behaviours. The plan of care for this resident showed that the resident had responsive behaviours but the plan of care did not include the identification of triggers. The interventions in the plan of care were not changed or updated in care plans.

During an interview with a specific staff member, they said they had received no clear direction on using the “Responsive Behaviour Tracking Record”. They said they thought it was just a form used on admission and they said it had not been used routinely. They said they had seen the “Responsive Behaviours Potential Triggers -

Checklist" in admission packages, but was unsure who was responsible to fill it out and update it. They said they were not familiar with the "Resident Behaviour Management" policy and they did not use the "Responsive Behaviour Tracking Record" or assess the records as the charge nurse as per policy. They also said they are not familiar with the "Responsive Behaviours Decision Tree." The staff member said they were familiar with this identified resident and there were specific interventions staff used for responsive behaviours. The staff member said this resident had been having ongoing behaviours, so definitely should have had updated assessments and they thought nothing had been updated.

During an interview with another staff member they stated they did not know who in the home was responsible for initiating the "Responsive Behaviours Triggers - Checklist" and they said they had never seen that form before and were not sure who updated it or how often it was to be updated. The staff member said they could not find any "Responsive Behaviours Tracking Records" for this resident for documented incidents of behaviours. They could not find any charting showing that triggers and interventions were updated after a specific incident. They said staff should have assessed this resident and put interventions in place as per the policy.

During an interview with the Director of Care (DOC), they said they were the lead for the responsive behaviour program in the home but had just recently started in that role. The DOC said staff were to use the "Responsive Behaviours Potential Triggers-Checklist" and "Responsive Behaviour Tracking Record" to update residents care plans. They said they did not have records that monitoring of responsive behaviours documentation had occurred as per the policy. They said they had not reviewed the behaviours policy or read it since starting work at the home. The DOC said they did not know how care plans were being updated if tracking tools were not being used.

Based on these interviews and record reviews this identified resident demonstrated frequent responsive behaviours prior to the Critical Incident and their behaviours escalated further after that incident. Although strategies had been initiated to identify triggers and respond to the behaviours, the actions taken within the home to meet the needs of this resident related to responsive behaviours did not include documented assessments or reassessments, the identification of triggers in the plan of care, the consistent implementation of interventions or documentation of the effectiveness of the interventions. (745)

C) The home submitted a Critical Incident System (CIS) report to the MOHLTC, related to physical altercations between two identified residents.

Observations by Inspector #745 during the inspection found this identified resident exhibited specific responsive behaviours.

During an interview with a staff member, they stated they were familiar with this resident and this resident did have responsive behaviours. The staff member said that there had not been a referral made to the BSO program in the home for this resident. During an interview with another staff member they said this resident had responsive behaviours. They said each shift the staff would document in mood and behaviours in Point of Care (POC) but was not aware if anything was done with that charting.

In an interview with another staff member they said they were familiar with this resident and this was a resident with responsive behaviours. The staff member said they thought responsive behaviours were documented each shift by staff in the electronic documentation system under mood and behaviours but they were not sure.

The clinical record for this identified resident included progress notes which showed this resident had specific responsive behaviours on specific dates. There was a "Responsive Behaviours Potential Triggers Checklist" in the hard copy chart dated 2017 with no other completed checklists since that time. No "Responsive Behaviour Tracking Records" were found for any documented incidents of behaviours. There were no documented assessments or reassessments of this resident's behaviours. The plan of care for this resident showed that the resident had responsive behaviours but the plan of care did not include triggers and interventions were not changed or updated in care plans.

During an interview with the Assistant Director of Care (ADOC) they said that nurses normally completed the "Responsive Behaviours Potential Triggers- Checklist" on admission and whenever there was a behaviour that was not normal. The ADOC said staff should monitor behaviours for three days after incident in a behaviour progress note and that DOS should also be completed.

Based on these interviews and record reviews, this identified resident was

demonstrating frequent responsive behaviours. The strategies that were developed to identify triggers and respond to the behaviours were not all identified in the plan of care or consistently implemented to respond to these behaviours. The actions taken within the home to meet the needs of the resident related to responsive behaviours did not include documented assessments or reassessments. (745) [s. 53. (4)]

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of this issue was level 3 as 3 out of three residents were affected. The home has a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 25, 2017 (2016_303563_0042);
- WN and VPC issued May 24, 2017 (2016_229213_0039). (730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2019(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 18th day of October, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMIE GIBBS-WARD (630) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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