Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2017	2017_563670_0023	019008-17	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Aylmer Long Term Care Residence
465 TALBOT STREET WEST AYLMER ON N5H 1K8

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

DEBRA CHURCHER (670), ALICIA MARLATT (590), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 5, 6, 7, 11, 12, 13, 14 and 15, 2017.

The following Critical Incidents were completed within the RQI:
Log#027728-16 CIS#2740-000011-16 related to a fall with injury.
Log#016255-17 CIS#2740-000008-17 related to a fall with injury.
Log#010250-17 CIS#2740-000005-17 related to a fall with injury.
Log#011180-17 CIS#2740-000006-17 related to a fall with injury.
Log#007186-17 CIS#2740-000004-17 related to improper care.
Log#012302-16 CIS#2740-000007-16 related to alleged staff to resident abuse.
Log#007033-16 CIS#2740-000004-16 related to alleged staff to resident abuse.
Log#004806-15 CIS#2740-000004-15 related to a missing controlled substance.

During the course of the inspection, the inspector(s) spoke with more than forty residents, Family Council representative, Residents' Council representative, the Administrator, the Director of Care, the Pharmacy Manager, the Food Service Manager, the Business Office Manager, the Personal Support Worker Coordinator, the Program Manager, one Cook, one Assistant Cook, three Registered Nurses, seven Registered Practical Nurses and seventeen Personal Support Workers.

During the course of the inspection, the inspectors toured all resident home areas, observed dining services, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

- **12 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care regarding a resident that did not receive their specialized diet.

The home's internal investigation into the incident stated that a resident required a specialized diet. The Food Service Manager (FSM) told the inspector that the home keeps samples of each food item prepared for all meals in the freezer for at least one week , and further that they examined a food sample for the meal service that resulted in the incident and identified that the food was not prepared appropriately.

The home's policy titled Resident List, last updated January 2017, gave clear direction and examples of how to prepare a specialized diet.

The Inspector observed the mid-day meal on a specific date. The Inspector observed that the specialized diet was not prepared correctly. FSM observed the specialized diet and acknowledged that the specialized diet was not prepared correctly, was a safety risk and would not be served in that state.

The Assistant Cook acknowledged that they had prepared the specialized diet that day and stated that they had no concerns with the food and thought that it was prepared properly.

The Cook stated that they had not performed any quality control for the specialized diet on that day.

The Administrator acknowledged that the specialized diet observed by the inspector was unsafe and staff were not performing effective quality control which placed any resident requiring a specialized diet at risk.

This licensee has failed to ensure that residents were provided with food and fluids that were safe.

The severity of this non-compliance is actual harm/risk and the scope was widespread. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 11. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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 the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Minimum Data Set (MDS) documentation for a specific date, stated that a specific resident had a change in their care needs.

A Registered Practical Nurse (RPN) acknowledged that the resident's care needs had changed from their their previous MDS assessment.

The Inspector was unable to locate any plan of care related to the resident's care needs.

The home's policy LTC-CA-WQ-100-02-17, titled Resident Care Plan's, last revised November 2014, stated "Ongoing, the care as set out in the care plan will be reviewed, evaluated and revised. Revisions may be required when interventions are no longer effective, as the resident condition changes or as target dates for goal statements come due".

An RPN acknowledged that there was no plan of care related to the resident's changed care needs.

The Director of Care (DOC) stated that the care plan should include the resident's current care needs, preferences and needs and that the care plan should be updated whenever there was a change in condition or needs.

The licensee has failed to ensure the resident's care plan was revised as required.

The severity of this non-compliance is a level two minimal harm or potential for actual harm and the scope was isolated. There was a compliance history of this legislation being issued in the home on October 27, 2016, as a voluntary plan of correction (VPC) in a Resident Quality Inspection #2016_258519_0016. [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, (b) 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The home's policy, "200-Clinical Nursing Services" "05-Palliative, Pain and Symptom Control" policy number LTC-CA-WQ-200-05-04 revised July 2016 stated, "If the assessment indicates pain is present (J2a or J2b greater than 0), further assessment and investigation may be required based on the interdisciplinary team's knowledge of the resident and their current status. Documentation to support further investigation following the RAI MDS assessment can be completed using the Comprehensive Pain Assessment" in Point Click Care. The policy also stated that staff will "complete a new Comprehensive Pain Assessment Tool when a resident reports new pain that is not episodic in nature or an exacerbation of existing pain that is not easily addressed with medication adjustment."

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care, stating that a resident had an incident with injury at the home.

Review of the resident's progress notes showed that the resident experienced an incident with injury at the home. Subsequent progress notes for three specific dates stated that the resident was experiencing pain on seven occasions.

Review of resident's comprehensive pain assessments in Point Click Care (PCC) showed that there was no pain assessment completed for three specific dates.

In an interview with the DOC, they shared that they would expect a pain assessment to be completed for this resident's new complaints of pain as per the home's pain policy.

B) Review of a resident's Minimum Data Set (MDS) assessment on a specific date post admission, identified that the resident was having moderate pain daily or severe pain at any frequency.

The resident's MDS assessment completed on admission, showed that the resident was not having any pain.

Review of the resident's progress notes showed that the resident had an incident with injury in the home on a specific date.

Review of resident's comprehensive pain assessments, in Point Click Care (PCC) showed that there was a pain assessment completed on three specific dates.

In an interview with the DOC, they shared that they would expect a pain assessment to be completed at specific times for a resident with a specific injury, and not three days later.

C) Review of a specific resident's Minimum Data Set (MDS) assessment identified that the resident was having pain moderate pain daily or severe pain at any frequency.

The resident's MDS assessment completed on a specific date, showed that the resident was having daily pain. The subsequent quarterly MDS assessment, showed that this resident was having mild pain, less than daily.

Review of the resident's progress notes showed six entries, over twenty five days, documented by staff members that the resident was experiencing pain.

Review of the resident's comprehensive pain assessments in Point Click Care (PCC) showed that there were pain assessments completed on three specific dates.

In an interview with the DOC, inspector explained that the resident first complained of pain on a specific date, and did not have a comprehensive pain assessment until eighteen days later. The DOC shared that they would expect a pain assessment to be completed for a resident experiencing new pain as per the home's pain policy.

D) A specific resident had a greater pain frequency or intensity according to the most recent Minimum Data Set (MDS) assessment relative to the previous assessment.

A Pain Assessment was completed in PCC on a specific date indicated "no pain". A comprehensive pain assessment was not completed when pain was identified during the MDS observation period ending on a specific date. The assessment was done seven days later and the resident did not report pain.

On September 11, 2017, the Director of Care (DOC) shared the expectation was that registered staff were to complete a pain assessment in PCC for a pain scale greater than "0" as identified in the MDS assessment in section J. The DOC shared the pain assessment would be completed related to the information captured in the MDS, as well as the progress notes in PCC, and the reporting of pain by the resident.

The Inspector reviewed the MDS dated for a specific date, where moderate pain less than daily was identified, and in the Pain Assessment dated for a specific date, it documented "no pain" as reported by the resident. The DOC acknowledged that at the time of the assessment the resident reported no pain and that the moderate pain less than daily was not assessed using the Pain Assessment tool in PCC.

The licensee has failed to ensure that the pain policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

The Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 135 (1)(b) states, "Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider."

The home's policy "200 – Clinical and Resident Care" policy # LTC-CA-WQ-200-06-11 for "Medical Incidents" last revised January 2017, stated medication errors were to be reported to the Director of Care or designate, physician/nurse practitioner and when appropriate to the pharmacist.

The Classic Care Pharmacy "Reporting Medication Incidents" policy number 7.3 last revised July 2014, stated all incidents regardless of origin are communicated to Classic Care Pharmacy by providing a completed medication incident form.

Four of the nine medication incidents that occurred between two specific dates, were reported to pharmacy.

On September 15, 2017, Director of Care (DOC) acknowledged that the medication incident policy for Chartwell Aylmer did not direct staff to report every medication incident involving a resident and every adverse drug reaction to pharmacy. Also, since June 2017, all Medication Incident Reports (MIRs) have been faxed to pharmacy and that the previous pharmacy did not request that all MIRs be faxed. The DOC also verified that staff were only following the home's policy.

The licensee has failed to ensure that the home's policy "200 – Clinical and Resident Care" policy # LTC-CA-WQ-200-06-11 for "Medical Incidents" instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

The severity of this non-complaince was a level two minimal harm or potential for actual harm, the scope was widespread. There was a compliance history of this legislation being issued in the home on July 27, 2015, as a voluntary plan of correction (VPC) in a Resident Quality Inspection #2015_303563_0027. [s. 8. (1) (a),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, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #4: 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 had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care on a specific date, that stated a resident had an incident with injury in the home.

The resident's risk management reports showed that the resident had experienced similar incidents on thirteen occasions in a seven month time period.

Review of the resident's risk assessments showed that the resident was assessed as a high risk for falls on five specific dates.

Review of the resident's completed Post Fall Analysis showed that, during this resident's stay in the home, only one Post Fall Analysis had been completed on a specific date.

Review of the home's policy related to falls titled "Resident Falls", policy number LTC-CA-WQ-200-07-08 with an effective date of February 2007, stated in part that:

"Post Fall Analysis:
1. Following a resident fall, Registered Staff will review the residents fall history to determnie how many falls the resident has had in the month and how many falls the resident has had in the quarter (Quarters are set quarters of January to March, April to June, July to September and October to December).
2. Combined with the level of risk related to falls, Registered Staff will use the number of falls in the month and quarter to determine if a Post Fall Analysis is to be completed.
3. See Appendix 1 for the Decision Tree
For High Risk Resident: If this is the first fall in the quarter - complete the following: Risk Management - PCC, Progress Note using the "Occurrence Note" note type, Post Fall Analysis in PCC. If this fall is more than the first fall in the quarter - complete the following: Risk Management - PCC and Progress Note using the "Occurrence Note" note type. The disciplinary team is responsible for meeting and completing the Post Fall Analysis. Further they are responsible for implementation and subsequent evaluation of interventions implemented as a result of the analysis."

In an interview with a Registered Nurse (RN), they shared that a Post Fall Analysis were not completed for every fall and would depend on the resident's current fall risk and how many falls they have had in the quarter. They shared that if it was the resident's first fall in the quarter and the resident was a high fall risk, a Post Fall Analysis should be completed by registered staff in Point Click Care (PCC).

In an interview with the Director of Care (DOC), they shared that a Post Fall Analysis may not necessarily be completed for every fall. They shared that the staff use an alogrithm to determine if a Post Fall Analysis should be completed. They said that a Post Fall Analysis should have been completed for the resident's falls on two specific dates, as both those falls were the first falls for this resident in the identified quarter.

B) A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care on a specific date, that stated a resident had fallen on a specific date.

Review of the resident's risk management reports for for a specific year showed that the resident had fallen on two separate occasions within five days of each other.

Review of the resident's completed fall risk assessments showed that the resident was assessed as a medium risk for falls on a specific date and a high falls risk on a subsequent date.

Review of the resident's completed Post Fall Analysis showed that two Post Fall Analysis' had been completed for the falls on two specific dates. The Inspector was unable to locate a completed Post Fall Analysis for the fall dated for a specific date.

During an interview with an RN, they shared that a Post Fall Analysis was not completed for every fall and would depend on the resident's current fall risk and how many falls they have had in the quarter. They shared that if it was the resident's first fall in the quarter and the resident was a high fall risk, a post fall analysis should be completed by registered staff in Point Click Care (PCC).

In an interview with DOC, they shared that a Post Fall Analysis may not necessarily be completed for every fall. They shared that the staff used an alogrithm to determine if a Post Fall Analysis should be completed. They shared that Post Fall Analysis should be completed when the resident was a high risk for falls and their last fall was greater than 90 days ago. DOC clarified that they were unaware that the Falls policy outlined the dates of quarters and had directed staff that there was no need to complete Post Fall Analysis if the resident had fallen within the past 90 days. DOC agreed that a Post Fall Analysis should have been completed.

The severity of this non-compliance is a level two, minimal harm or potential for actual harm and the scope is a pattern. The home has a compliance history of one or more unrelated non-compliance in the last three years. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Critical Incident Systems (CIS) Report was submitted to the Ministry of Health and Long-Term Care on a specific date. The CIS documented that a specific resident had increasing pain and an injury.

The Pain Assessments completed in Point Click Care (PCC) over a time period of seven months identified that the resident had experienced pain in multiple sites.

The last pain assessment for the resident was completed on a specific date, prior to the identification of the resident's injury. There were multiple progress notes that documented multiple pain sites and levels of pain over three months, when the last two pain assessments were completed in PCC.

Review of the resident's progress notes for the three month period prior to the identification of the resident's injury, documented ten instances were the analgesic administration was ineffective.

The home's policy "200-Clinical Nursing Services" "05-Palliative, Pain and Symptom Control" policy number LTC-CA-WQ-200-05-04 revised July 2016, stated that staff will "complete a new Comprehensive Pain Assessment Tool when a resident reports an exacerbation of existing pain that is not easily addressed with medication adjustment".

On September 11, 2017, Director of Care shared the registered staff should have completed a pain assessment in PCC for a pain scale greater than 0 as identified in the MDS assessment in section J; as well as the reporting of pain by the resident in the progress notes in PCC.

On September 13, 2017, and RN shared that the process that should be followed in the home is that pain assessments are completed by registered staff and are documented in PCC. Pain assessments are completed on admission, with new pain, new medication, changes to medication dosages or when a medication was stopped. The RN also shared that any unmanaged pain, such as with the use of an as needed “PRN” medication was reported to the physician.

On September 14, 2017, the DOC acknowledged that a resident experiencing new or worsening pain required a comprehensive pain assessment in PCC and shared that a resident who had episodic pain would have other documentation completed other than a pain assessment in PCC; such as a progress note, or a pain scale at the time of administration.

The licensee has failed to ensure that resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when pain was not relieved by initial interventions. The resident had unresolved pain with the administration of analgesics on multiple occasions over a three month period, without the completion of a clinically appropriate assessment instrument specifically designed for pain.

The severity of this non-compliance is a level two, minimal harm or potential for actual harm and the scope is a pattern. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On September 12, 2017, the narcotic count was observed at shift change with two Registered Practical Nurse's (RPN) present in the Tulip Trail medication room at 1435 hours. RPN #113 was the staff member at the count sheet binder and RPN #120 was the on coming staff member counting at the narcotic bin. RPN #113 noted that there was a missed dose of Dilaudid 0.5 milligrams (mg) on the "Resident's Individual Narcotic and Controlled Drug Count Sheet" for a specific resident. RPN #113 acknowledged that the medication was missed as there should have been one less dose during the narcotic count, and the 1200 hour dose of a specific medication was not administered.

The "Resident's Individual Narcotic and Controlled Drug Count Sheet" dated September 12, 2017 at 0510 hours, documented the administration of one dose of a specific medication, leaving two tablets left in the package. There was no documentation that a dose was used at 1200 hours. Two tablets of a specific medication were observed in the package when there should have been one left.

The Risk Management module in Point Click Care documented the medication incident for the resident.. The incident report noted that during shift change there was an omission of a narcotic at lunch on September 12, 2017.

Review of the electronic medication administration record (eMAR) stated the medication was signed as given, but RPN #113 verified that it was not administered to the resident in accordance with the directions for use at 1200 hours specified by the prescriber.

The severity of this non-compliance is a level two, minimal harm or potential for actual harm and the scope is a pattern. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitued Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident

and the pharmacy service provider.

The following medication incidents were review with the Director of Care (DOC) on September 15, 2017:
A) On a specific date, a Medication Incident Report (MIR) was completed for a resident who was given an overdose of a specific medication on two specific dates. The MIR documented that a specific resident received three doses of a specific medication on two specific dates.

The Medication Administration Record (MAR) for a specific month, documented that a "specific medication tablet by mouth as needed for a specific condition daily" was administered at three separate times on a specific date. The MAR for the subsequent specific month documented that "a specific medication tablet by mouth as needed for a specific condition, twice daily (BID) as needed (PRN)" was administered at three separate times on a specific date.

On September 15, 2017, the Director of Care (DOC) shared that there was no notification to the DOC and that no one was notified of the incident. The DOC acknowledged that the immediate action documented as part of the MIR that stated, "reported to DOC" did not occur by email. The DOC shared that the process was that the staff member involved in the medication incident was emailed by the staff member who discovered the incident and the DOC was to be copied on the email so that the DOC could follow up.

B) On a specific date, a MIR was completed for a resident who missed multiple doses of a specific medication. The MIR documented the resident had specific symptoms and upon investigation noted that the medication was ordered on a specific date, daily at a specific time for one week and then if tolerated increase to twice daily; however the medication had not been given for six days .

On September 15, 2017, the DOC shared that no one was notified of the incident. The DOC shared that nursing staff were to notify pharmacy that the drug was tolerated so that pharmacy could then dispense the medication twice daily.

On September 15, 2017, Pharmacy Manager, shared that Classic Care became the pharmacy service provider in February 2017, with a go live date of February 22, 2017. The Pharmacy Manager shared that all medication incident reports were to be faxed to pharmacy, both of a pharmacy and nursing origin and then reviewed for trends. The MIR related to a specific resident was prior to the service agreement with Classic Care

Pharmacy and a specific resident's MIR was not faxed.

The Professional Advisory Committee meeting minutes dated September 6, 2017, documented eleven MIRs. Nine of the eleven incidents occurred when Classic Care was the pharmacy provider. Pharmacy Manager shared that four of the nine incidents during a seven month period, were not faxed to pharmacy.

The licensee failed to ensure that the medication incident involving a specific resident was documented with a record of the immediate actions taken. The incidents involving two resident's were not reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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

The following medication incidents were reviewed with the Director of Care (DOC) on September 15, 2017:
A) On a specific date, a Medication Incident Report (MIR) was completed for a specific resident who was given an overdose of a specific medication on two specific dates. On September 15, 2017, the DOC shared that there was no corrective action taken with the two Registered Practical Nurses involved and that there should have been some follow up.

B) On a specific date a MIR was completed for a specific resident who missed multiple doses of a specific medication. The DOC shared that there was no corrective action taken with the any of the registered nursing staff involved. The incident was not analyzed and there was no follow up by the DOC.

On September 15, 2017, Pharmacy Manager shared that Classic Care Pharmacy only prepared a response outlining the corrective action and analysis of pharmacy errors and faxed the responses to the DOC for review.

The licensee has failed to ensure that the medication incidents were analyzed and corrective action was taken. [s. 135. (2)]

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

The Chartwell Aylmer Professional Advisory Committee (PAC) meeting minutes dated March 8, 2017 and June 7, 2017, did not include documented evidence that medication incidents were reviewed by the team members on this date. The Chartwell Aylmer PAC meeting minutes dated September 6, 2017, documented that eleven medication incidents were reported for the time period of January to August 2017. A quarterly review was not documented related to medication incidents.

On September 15, 2017, Director of Care (DOC) shared that when reading the meeting minutes for September 6, 2017, there was not enough detail written as part of the quarterly review undertaken of all medication incidents and adverse drug reactions that occurred between January to August 2017, and the changes and improvements identified in the review were not documented.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home, changes and improvements were not identified and a written record was not kept of everything.

The severity of this non-compliance is a level two, minimal harm or potential for actual harm and the scope is a pattern. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician or registered nurse in the extended class; to ensure that all medication incidents and adverse drug reactions are reviewed and analyzed and corrective action is taken as necessary; to ensure that a quarterly review is undertaken of all medication incidents and adverse reactions that have occurred in the home since the time of the last review and a written record is kept, to be implemented voluntarily.

WN #8: 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 any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Review of the home's investigation and submitted Critical Incident System report (CIS) stated that a Personal Support Worker (PSW) had reported alleged staff abuse towards a specific resident, to the home on a specific date. The CIS stated the incident occurred on a specific date at a specific time and the home did not submit the CIS report to the Ministry of Health and Long-Term Care until the following day at a specific time.

The home's policy titled Abuse Free Communities, Prevention, Education and Analysis, last revised July 2016, stated "Mandatory reporting by all persons means all persons (i.e. employees, volunteers, family members, Substitute Decisions Makers (SDMS), Power Of Attorney (POA), Long Term Care Home Staff and Long Term Care Home Operators), who have reasonable grounds to suspect the occurrence of any of the following events, either presently or in the near future are legally obligated to immediately report the suspicion and the information upon which it is based to regulatory bodies including MOHLTC, Director, Regional Health Authorities and other provincial licensing/certification authorities."

"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."

The Administrator stated that any suspicions of abuse should be reported immediately and that the CIS report should have been completed and submitted on the date the incident was reported to the home.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse had occurred shall immediately report the suspicion and the information upon which is is based, to the Director.

The severity of this non-compliance was a level one, minimum risk and the scope was isolated. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 24. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted before hiring a staff member or accepting volunteers who are 18 years of age or older.

The Inspector reviewed three staff files of staff that were hired within a specific time frame. The files stated that a specific PSW and a specific RPN had vulnerable sector checks in their files. A specific PSW's file contained a criminal record check dated for a specific date, but did not contain a vulnerable sector check. The file contained a receipt showing that there had been an application for a vulnerable sector check on a specific date. The file contained a letter of offer dated for a specific date.

The home's policy titled Criminal Background Checks, last revised January 2014, stated "Candidates for employment or a volunteer position shall undergo a background check as a condition of employment the background check is to be completed by all candidates for employment or a volunteer position prior to commencing employment in a Chartwell facility. The background check shall include a Criminal Reference Check and a Vulnerable Sector Screen."

The Business Manager reviewed the specific PSW's time card with the Inspector. The time card stated that the PSW had oriented on a specific date, for five hours and for seven and a half hours each day on four subsequent specific dates and three hours on one additional specific date. The Business Manager stated that two of the dates were orientation days were paperwork and education with no interaction with residents and four of the orientation dates were floor orientations which would involve the employee providing care to residents with a preceptor in attendance.

The Administrator acknowledged that the home's policy required a staff member to have a vulnerable sector check prior to starting work and acknowledged that the specific PSW did not have a vulnerable sector check and stated that the PSW should not have been allowed to work with residents until the vulnerable sector check was received and that they "missed it".

The licensee has failed to ensure that criminal reference checks were conducted before hiring a staff member or accepting volunteers who are 18 years of age or older.

The severity of this non-compliance was a level one, minimum risk and the scope was isolated. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 75. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Critical Incident System report (CIS) stated that a Personal Support Worker (PSW) had reported alleged staff abuse towards a specific resident to the home on a specific date.

The Inspector was unable to locate any documentation that the Substitute Decision Maker (SDM) was notified.

The home's policy titled Abuse Allegations and Follow Up, last revised July 26, 2016,

stated "Notification and Reporting Requirement. Family/Substitute Decision Maker and/or Power of Attorney-immediate notification when there is alleged, suspected or witnessed abuse."

The Director of Care (DOC) acknowledged that there was no documentation of the SDM being notified and stated that if it was not documented that the SDM was probably not notified.

The Administrator acknowledged that the SDM was not notified and stated that the SDM should have be notified immediately.

The licensee has failed to ensure that the resident's SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Review of the home's investigation and submitted CIS report stated that a Personal Support Worker (PSW) had reported alleged staff abuse towards a specific resident to the home on a specific date. The home conducted an investigation into the allegations the following day.

The Inspector was unable to locate any documentation that the SDM was notified of the results of the investigation.

The home's policy titled Abuse Allegations and Follow Up, last revised July 26, 2016 stated "Notification and Reporting Requirement. Immediately, upon the completion of the investigation the ADMIN/DOC or designate must review the results of the investigation with the resident and the resident's identified person (family/POA/SDM/Friend)"

The Administrator acknowledged that the SDM was not notified of the results of the investigation and stated that it was the expectation of the home that the SDM would be notified immediately.

The Licensee has failed to ensure that the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The severity of this non-compliance was a level one, minimum risk and the scope was isolated. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 97. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Review of the home's investigation and submitted Critical Incident System report (CIS) stated that a Personal Support Worker (PSW) had reported alleged staff, verbal abuse towards a resident to the home on a specific date. The home conducted an investigation into the allegations on the following day. The initial report to the home was verbal abuse however later in the evening on the specific date the incident was reported, during care, staff noted an injury to the resident. The home's internal investigation was inconclusive if the injury was related to the reported alleged abuse.

The Inspector was unable to locate any documentation that the police were notified.

The home's policy titled Abuse Allegations and Follow Up, last revised July 26, 2016 stated "Notification and Reporting Requirement. Immediate to Police, as applicable if the act may constitute a criminal offence. Police are the only authority who can determine this."

The Administrator acknowledged that the police were not notified and should have been notified when the home suspected physical abuse.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse.

The severity of this non-compliance was a level one, minimum risk and the scope was isolated. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 98.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

On September 15, 2017, the Tulip Trail medication room refrigerator was observed to have a portable locked black metal box inside. A Registered Nurse (RN) verified there was a black box in the fridge with a vial of Ativan injectable inside and the box was not stationary. The RN acknowledged The Controlled Drugs and Substances Act classified Ativan as a controlled substance.

The "Administration, Documentation and Storage" policy number 4.8, last revised July 2014, stated "Controlled Substances are stored in a stationary narcotic cupboard or box in the medication room.

The Director of Care (DOC) acknowledged that the Ativan should be stored in a separate, double-locked stationary cupboard and that the black box was not stationary.

The licensee has failed to ensure that the injectable Ativan was stored in a separate, double-locked stationary cupboard in the locked medication room.

The severity of this non-compliance was a level one, minimum risk and the scope was isolated. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 129. (1) (b)]

Issued on this 17th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBRA CHURCHER (670), ALICIA MARLATT (590), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2017_563670_0023
Log No. / No de registre :	019008-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 7, 2017
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Aylmer Long Term Care Residence 465 TALBOT STREET WEST, AYLMER, ON, N5H-1K8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Demaiter

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

1) The licensee shall ensure that all foods and fluids provided to residents requiring a specialized diet is safe for consumption.

2)The licensee shall implement quality control processes that are documented and ensure that specialized diets are safe for consumption.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care regarding a resident that did not receive their specialized diet.

The home's internal investigation into the incident stated that a resident required a specialized diet. The Food Service Manager (FSM) told the inspector that the home keeps samples of each food item prepared for all meals in the freezer for at least one week , and further that they examined a food sample for the meal service that resulted in the incident and identified that the food was not prepared appropriately.

The home's policy titled Resident List, last updated January 2017, gave clear direction and examples of how to prepare a specialized diet.

The Inspector observed the mid-day meal on a specific date. The Inspector observed that the specialized diet was not prepared correctly. FSM observed the specialized diet and acknowledged that the specialized diet was not

prepared correctly, was a safety risk and would not be served in that state.

The Assistant Cook acknowledged that they had prepared the specialized diet that day and stated that they had no concerns with the food and thought that it was prepared properly.

The Cook stated that they had not performed any quality control for the specialized diet on that day.

The Administrator acknowledged that the specialized diet observed by the inspector was unsafe and staff were not performing effective quality control which placed any resident requiring a specialized diet at risk.

This licensee has failed to ensure that residents were provided with food and fluids that were safe.

The severity of this non-compliance is actual harm/risk and the scope was widespread. The home has a compliance history of one or more unrelated non-compliance in the last three years. [s. 11. (2)] (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 02, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 7th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Debra Churcher

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