Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 25, 2014	2014_265526_0012	H-000640-14	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

CHATEAU GARDENS NIAGARA LONG TERM CARE CENTRE
120 WELLINGTON STREET, P.O. BOX 985, NIAGARA-ON-THE-LAKE, ON, L0S-1J0

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

THERESA MCMILLAN (526), MICHELLE WARRENER (107), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 3, 4, 5, 6, 9, 10, 11, and 12, 2014.

During this RQI, H-000640-14, two Critical Incident inspections were conducted and the findings are part of this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager, Environmental Services Manager, Program Support Services Manager, Business Manager, Resident Assessment Inventory Minimum Data Set (RAI MDS) Coordinator, Registered Dietitian (RD), registered staff including Registered Nurses (RN's) and Registered Practical Nurses (RPN's) and Personal Support Workers (PSW's), Housekeepers, Dietary staff, Recreation staff, Physiotherapist, Physiotherapy Assistant, residents and family members

During the course of the inspection, the inspector(s) toured the home; reviewed policies and procedures, meeting minutes, resident health records, dietary menus and staff files; and observed residents in their living and dining areas

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident; (b) the goals the care was intended to achieve; and (c) clear directions to staff and others who provided direct care to the resident.

Resident #004 stated that staff would sometimes help with oral care, depending on the staff. A Personal Support Worker (PSW) described the resident's care needs according to their experience with caring for the resident. However, a review of the written plan of care did not include any information regarding oral care. Interview with the Resident Assessment Inventory Minimum Data Set (RAI MDS) Coordinator who

completed the coding and care plan confirmed the omission of oral care and that the written plan of care for resident #004 did not include the planned care for the resident, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (a)]

2. The licensee did not ensure that the plan of care for resident #032 set out clear directions to staff and others who provided direct care to the resident in relation to oral hygiene. While the resident's plan of care directed staff to provide total assistance with mouth care, the plan of care did not specify the frequency or method to provide the care. Documentation did not consistently reflect that the resident was offered oral care a minimum of twice daily for an eleven day period. [s. 6. (1) (c)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

(A) A review of resident #004's clinical records and RAI MDS quarterly assessment outlined the resident's behavioural symptoms. Over three quarterly assessments the resident had demonstrated changes in behaviours. However, section E5 indicated that resident #004 had no change in behavioural symptoms as compared to 90 days ago. The physician assessment conducted just following the last assessment confirmed resident #004 had changes in their behaviours. Interview with the RAI MDS coding nurse confirmed the RAI MDS assessments were not integrated, consistent or complimented each other.(511)

(B) Two of resident #023's RAI MDS quarterly assessments for Communication/Hearing Patterns conducted in 2013 indicated that there had been changes in the resident's ability to make themselves understood and in how they understood others. However, the RAI MDS assessment Section C indicated that there was no change from 90 days previous or since last assessment if less than 90 days. The assessments were not integrated and did not complement each other in noting a change in the resident's communication patterns. (526)

(C) Resident #032's RAI MDS assessment completed in 2013 indicated that the resident required assistance with communication. The coding on the resident's next RAI MDS assessment three months later indicated that the resident did not have any any communication devices/techniques. However, the coding for that assessment and

(Resident Assessment Protocol Sheet) RAPS indicated that there was no change in the resident's communication, despite the change in the use of communication device as indicated in the previous assessment. The coding and RAPs were not consistent with the change in the use of a communication device. Staff interview confirmed that the communication device was no longer useful so it was removed from the resident's plan of care. (107) [s. 6. (4) (a)]

4. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

(A) Resident #045 was a high risk for falls and sustained a fall in 2014 while the resident was sitting on the side of their bed, and was witnessed by non registered staff to slip off of the bed onto the floor landing on their buttocks. The resident complained of pain in a specific area of their body. The resident was sent to hospital, was diagnosed with a fracture, was found to be a poor candidate for surgery and was sent back to the home. The resident's status deteriorated in the home and the resident died.

Prior to the fall outlined above, resident #045 sustained 11 falls over 6 months. The resident's plan of care directed staff to "analyze previous falls to determine whether pattern can be addressed and prevented". Registered staff confirmed that the resident's 11 falls were not collectively analyzed in order to identify patterns to address and prevent future falls prior to the final fall. (526)

(B)The care set out in the plan of care for resident #042 was not provided to the resident as specified in the plan. The resident's plan of care required a bed alarm, however, this was not in place while the resident was sleeping in bed at the time of inspection. The alarm was still attached to the resident's wheelchair in their room. Registered staff confirmed that the bed alarm was required and attached the alarm to the bed. (107) [s. 6. (7)]

5. The licensee did not ensure that a resident's plan of care was reviewed and revised when the care set out in the plan was not effective.

(A) A nutritional assessment completed in 2013 for resident #044, indicated that the resident had weight loss, was below their goal weight range (prior to the weight loss), and had a goal for the prevention of further weight loss. However, interventions on the resident's plan of care were not revised in relation to the further weight loss.

In addition, nutritional interventions were not evaluated for effectiveness in relation to the goals identified in resident #044's plan of care. The Registered Dietitian (RD) confirmed that the plan of care was not revised in relation to the further weight loss. (107)

(B) Interventions identified in resident #037's plan of care were not evaluated for effectiveness in relation to goals established for the resident. Resident #037's plan of care was not revised after the resident's nutritional assessment indicated that the resident had significant weight loss. The RD wrote, "continue with all interventions as they meet needs".

The resident's plan of care identified a goal for the prevention of further weight loss. However, the nutritional assessment that was done two months later indicated that the resident had further weight loss, developed pressure areas on their skin, and had a decrease in their oral intake. The plan was not revised to address the prevention of further weight loss, nor were the goals revised when the plan was ineffective at preventing further weight loss. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 with section 6(10)c 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 care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that, a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

(A) A review of resident #004's clinical records indicated weekly skin and wound assessments for altered skin integrity during a month in 2014 for an extremity. A new weekly skin assessment and dietary referral was completed during that time for a different skin integrity issue for resident #004. There were no further weekly skin assessments using a clinically appropriate assessment instrument designed for skin and wound assessment for these alterations in skin integrity. Two weeks later a nursing progress note indicated the second skin integrity issue had been resolved.

During that month, three progress notes identified the first altered skin integrity issue using varying descriptors with interventions required. The dietary assessment conducted the following month referred to an alteration in skin integrity of the extremity with a different descriptor. An additional month later, a quarterly skin assessment was completed and indicated altered skin integrity however there were no further weekly skin assessments on file.

An interview with the DOC confirmed the home did not ensure that when resident #004 exhibited altered skin integrity they received weekly skin assessments using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

(B) Resident #026 developed altered skin integrity to an extremity during a month in 2014. One month later registered staff noted that the skin integrity issue had healed. Two weeks later, registered staff noted that resident #026 had the same altered skin integrity issue to the same area as two weeks earlier. Inspection of all health records during this time frame for resident #026 indicated that there were no further skin assessments of the resident's extremity for a period of one month following the identification of the more recent altered skin integrity. Staff and the ADOC confirmed that weekly assessments should have been conducted on this altered skin integrity until the wound was noted as being healed. (526) [s. 50. (2) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, 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 did not ensure that where the Act or this Regulation required 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 b) is complied with.

(A) The licensee did not ensure that the home's hypoglycemia policy (LTCE-CNS-C-04) was complied with for a resident experiencing hypoglycemia. (107)

(B) The home did not ensure that the Infection Control Manual Employee Wellness policy LTCE-INF-E-05 Tuberculosis Screening for Staff that was last revised on January 2014 was followed. The policy stated the following: "A 2-step TB test or chest x-ray with negative results shall be done pre-employment within 6 months and the results provided to the department manager. Note: if the employee has had a 2-step TST within the past 12 months and can provide proof of that, a one-step only is required."

Four staff health records were reviewed regarding the home's infection prevention and control program policies. One staff record indicated that the staff person was screened for tuberculosis (TB) greater than six months prior to starting employment at the home and was not rescreened for TB according the home's policy. The Assistant Director of Care (ADOC) confirmed that the home did not comply with the policy. (526) [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 where the Act or this Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

(A) Actions taken with respect to resident #032, including interventions, were not documented. The resident's plan of care directed staff to provide total assistance with oral care. Documentation related to oral hygiene was incomplete on the resident's flow sheets. The flow sheets, where staff document the care that was provided, indicated that the resident received oral care only once daily on during four days in one week in 2014. The PSW who routinely provided care to the resident stated that the resident had refused the oral care and that they had forgotten to document this on the flow sheets. (107)

(B) Actions regarding infection prevention and control were not documented. The health records for residents #004, #028, and #034 were reviewed and documentation of the administration of an immunization was absent. Registered staff and the ADOC confirmed that immunization administered was not explicitly included in the documentation of immunizations for residents. (526) [s. 30. (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 ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: 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 :

1. The licensee did not ensure staff used safe transferring and positioning devices or techniques when they assisted a resident.

Resident #009's plan of care indicated that staff were to use gentle care when transferring due to the resident's diagnosis. A record review indicated that on a day in 2014 resident #009 had been up in a Broda chair since approximately 1200 hours and had no complaints of pain. The resident would request to get up out of bed infrequently. Clinical records indicated the resident was transferred back from the Broda chair to the bed using a Hoyer lift approximately six hours later. Staff transferred the resident to bed using a transferring technique that did not ensure the resident's safety. The resident became upset and demonstrated both verbal and physical aggression towards the PSW's as they started to lift the resident in the Hoyer lift. The resident, as confirmed by the PSW, started immediately screaming in pain. The resident continued to complain of pain after the being returned to bed and was transferred to the hospital where they were diagnosed with a fracture.

An interview with the DOC indicated that staff had safe lift and transfer education and she confirmed that she concluded the resident had sustained the injury during the transfer; the technique used did not ensure the staff used a safe transferring and positioning technique when they assisted resident #009. [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 #6: 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 did not ensure that when a resident fell, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. Resident #045 was a high risk for falls and sustained a fall one day in 2014.
The resident was witnessed slipping off of the bed onto the floor landing on their buttocks. The resident complained of pain, was sent to hospital, and was diagnosed with a fracture. The resident was found to be a poor candidate for surgery and was sent back to the home. The resident's status deteriorated in the home and deceased at a later date.

The resident's health record did not include a post fall assessment or analysis of the fall that led to the resident's hospitalization. The DOC confirmed that no post falls assessment or analysis had been completed for that fall. [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 #7: 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 did not 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.

Review of the resident #009's clinical records indicated the resident started to complain of pain to one of their legs after a transfer from the chair to their bed. The resident's clinical record confirmed the resident received Tylenol plain (325mg) two tablets by mouth every four hours as needed for pain within a one week time period after the transfer. Clinical records indicated the resident continued to experience pain in one of their legs and was noted to be screaming every time the staff moved them; the leg remained reddened and painful to touch.

During one week after the transfer staff were in regular communication with the resident's physician and Nurse Practitioner and the resident was being actively treated for cellulitis during that time. After this period resident #009 was assessed by the Nurse Practitioner in consultation with with the physician at which time the resident's pain medication was increased from Tylenol to Morphine 2.5 mg by mouth to be given every eight hours as needed. The resident was sent to hospital for further assessment. The first comprehensive pain assessment was completed on the resident's return from the hospital with a diagnosis of a fracture. Interview with the DOC confirmed when the resident's pain was not relieved by initial interventions prior to being sent to hospital, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that all food was served at a temperature that was palatable to the residents. Residents had identified cold food temperatures. A review of the food temperature monitoring records reflected that foods served to residents were less than the required minimum food temperatures identified in the home's food temperature monitoring policy LTCE-FNS-D-02. The policy required foods to be hot held at a minimum of 140 degrees Fahrenheit (F). On May 17, 2014 at the breakfast meal, the pureed toast was served at 131 degrees F and 130.1 degrees F. On May 17, 2014 at the lunch meal the main starch was served at 139 degrees F and on May 21, 2014 the records reflected the main starch was 109 degree F.

Dietary staff confirmed during interview that they were unsure of what the home's policy was on minimum food temperatures (what temperature to take action) and confirmed that foods were served at the temperature that was recorded on the sheets. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, 6. Foods and fluids being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The lap belt for resident #041 was not applied according to manufacturer's instructions. The resident was observed with a loose fitting seatbelt (belt was just above the resident's knees) and the resident was unable to undo the seatbelt independently when asked by the inspector. Staff confirmed the resident was not able to undo the seatbelt independently, the device was not applied correctly and was too loose. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. to ensure that staff apply a physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #10: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee did not ensure that when a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical, (a) the staff member was trained by a member of the registered nursing staff in the administration of topicals; (b) the member of the registered nursing staff who was permitting the administration was satisfied that the staff member could safely administer the topical; and (c) the staff member who administered the topical did so under the supervision of the member of the registered nursing staff.

During 2014 resident #004 had a container of prescription topical cream in their bedside drawer. Interview with the full-time primary care PSW confirmed the staff member applied the topical cream on a regular basis during morning care. They stated that they tried to apply it daily as resident #004 had altered skin integrity to extremities. The PSW indicated the resident preferred to receive care only from

certain staff members. Altered skin integrity and resident behaviour was confirmed by a skin and wound assessment.

A review of the electronic treatment administration record (eTar) for resident #004 indicated the prescription topical cream had been ordered and then applied by registered staff three times over a seven month period. However, the prescription cream was refilled during this time and approximately 1/8 of this container had been used at the end of this time period, indicating the front line staff had been applying as stated. Interview with the registered staff indicated they were unaware the prescription cream was at the bedside and was being applied by the front line staff. Interview with the DOC confirmed the prescription cream was not to be kept at the resident bedside as the staff member who administered the topical did not do so under the supervision of the member of the registered nursing staff. [s. 131. (4)]

2. The licensee did not ensure that no resident who was permitted to administer a drug to himself or herself under subsection (5) to keep the drug on his or her person or in his or her room except, (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attended the resident; or (b) in accordance with any conditions that were imposed by the physician, the registered nurse in the extended class or other prescriber.

Resident #004 was observed to have prescription cream kept in the bedside drawer. Interview with the registered staff indicated that the resident was unable to apply the prescription cream safely as prescribed by the physician. There was no authorization by the prescriber in the resident's health record to keep the prescribed medication at the bedside. Interview with the DOC confirmed the prescription cream was not permitted to be at resident #004's bedside. [s. 131. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical if the staff member does so under the supervision of the member of the registered nursing staff; and to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and (b)in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff were screened for tuberculosis (TB) in accordance with evidence-based practices and if there were none, in accordance with prevailing practices. Four staff health records were reviewed; one staff did not have a TB screening on file. The ADOC verified that this staff person who was working in the home had not been adequately screened for TB. [s. 229. (10) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 8. That every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

(A) On June 5, 2014 at approximately 1430 hours, inspectors observed the Director of Care (DOC) conversing with a resident's family members in a sitting area at the entrance to the home. The family could be overheard sharing private information regarding the resident. Three groups of individuals entered the home and walked past the DOC speaking with the family members during the observation time. The Administrator confirmed that the DOC had access to the family room on the first floor to conduct private conversations with family members.

(B) On June 4, 2014 Inspector #526 observed resident #046 undressed from the waist down sitting on the toilet with the washroom door opened. The resident's roommate was sitting beside their bed and could view resident #046 while they were in the washroom. The resident was also seen from the bedroom door if it were opened. Upon interview resident #046 stated that they had just been admitted to the home. They found that the washroom was too small to accommodate a wheelchair and so the door was left ajar. They thought that this was a usual practice here but felt that residents should be afforded privacy when in the washroom.

(C) On June 9, 2014, Inspector #526 observed resident #014 receiving care by staff while the resident was in bed. The privacy curtain was partially drawn providing privacy from the door but was opened to the resident's room where three other residents resided. There were two residents observed in the room who could view the care being provided to resident #014. Staff confirmed that residents should be afforded privacy while care is provided. [s. 3. (1) 8.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The resident-staff communication and response system was not easily accessed and used by residents in a resident room during the time of inspection. The cord for the call bell in the washroom was wrapped around the grab bar and pulled so tight that the cord was unable to be pulled or grabbed. One of the residents in this room was physically capable of using the call bell if it was accessible. Staff confirmed the call bell cord was not to be wrapped around the grab bar in the washroom and noted the cord was too long for where it was positioned. [s. 17. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that resident #023's plan of care was based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language. Resident #023 had a known and diagnosed sensory deficit. RAI MDS assessments conducted over a nine month period addressed this deficit. However, care plans did not include goals and interventions to address the resident's sensory deficit. In addition, changes in the resident's communication abilities were not addressed in the resident's plan of care. Registered staff confirmed that the resident's communication patterns were not addressed in the plan of care.

2. The licensee did not ensure that a plan of care was based on an interdisciplinary assessment of resident #026's health conditions, including the resident's marked skin integrity issues in combination with other alterations in skin integrity.

During one week in June the resident was observed to have altered skin integrity on their extrimities. The resident's RAI MDS assessment Section M indicated that the resident had alterations in skin integrity although a detailed description of this skin problem was not noted. Staff confirmed that the resident's status and the resident's behaviour in relation to altered skin integrity. Registered staff confirmed that the resident's skin integrity was not regularly assessed or documented or prevention strategies included in the resident's plan of care. [s. 26. (3) 10.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered and available at the lunch meal on June 3, 2014. Resident #043 was not offered a meal according to the planned menu. The Dietary Aide stated that the resident was unable to tolerate a food group and an entire food group was being excluded from the resident's diet. An interview with the Food Services Manager and Registered Dietitian reflected that this information was not communicated and they were unaware of the problem. The resident was noted to have untoward effects requiring medication as a result of them not receiving the food group in their diet. [s. 71. (4)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. Not all menu items were prepared according to the planned menu at the lunch meal June 3, 2014. The posted menu included an Asian salad consisting of mandarin oranges, nappa cabbage, snow peas, green onions, and bean sprouts. The actual salad prepared and served to residents contained spinach, mandarin oranges, mushrooms, celery, and bean sprouts. The recipe for the salad contained spinach, bean sprouts, celery, mushrooms, peppers, and parsley. The salad prepared did not match the posted menu or recipe. The planned menu required the mandarin oranges to be served as dessert, however, they were included in the prepared salad. In addition, the posted menu indicated that dill pickles were to be served with the ham sandwich. Dill pickles were not available or offered to residents that chose the sandwich. Dietary staff confirmed that the items did not match the planned menu for that meal. [s. 72. (2) (d)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of laundry services under clause 15(1)(b) of the Act, residents' linens were changed at least once a week and more often as needed. Two days over a one week period in the middle of the day resident #047's bed had a urine odour emanating from it. The bed had been made and the linens were noted to be urine soaked and stained. A registered staff and non registered staff confirmed that the bed had been made for the day and that the linen was soiled and that it smelled of urine. [s. 89. (1) (a) (i)]

Issued on this 21st day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526), MICHELLE WARRENER (107), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_265526_0012
Log No. / Registre no:	H-000640-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 25, 2014
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	CHATEAU GARDENS NIAGARA LONG TERM CARE CENTRE 120 WELLINGTON STREET, P.O. BOX 985, NIAGARA-ON-THE-LAKE, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LORRAINE KOOP

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan shall be submitted by July 18, 2014 to Long Term Care Homes Inspector Theresa McMillan at Theresa.McMillan@Ontario.ca

Grounds / Motifs :

1. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

(A) Resident #045 was a high risk for falls and sustained a fall in 2014 while the resident was sitting on the side of their bed, and was witnessed by non registered staff to slip off of the bed onto the floor landing on their buttocks. The resident complained of pain in a specific area of their body. The resident was sent to hospital, was diagnosed with a fracture, was found to be a poor candidate for surgery and was sent back to the home. The resident's status deteriorated in the home and the resident died.

Prior to the fall outlined above, resident #045 sustained 11 falls over 6 months. The resident's plan of care directed staff to "analyze previous falls to determine whether pattern can be addressed and prevented". Registered staff confirmed that the resident's 11 falls were not collectively analyzed in order to identify patterns to address and prevent future falls prior to the final fall. (526)

(B)The care set out in the plan of care for resident #042 was not provided to the resident as specified in the plan. The resident's plan of care required a bed alarm, however, this was not in place while the resident was sleeping in bed at the time of inspection. The alarm was still attached to the resident's wheelchair in their room. Registered staff confirmed that the bed alarm was required and attached the alarm to the bed. (107)
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan shall be submitted by July 18, 2014 to Long-Term Care Homes Inspector Theresa McMillan at Theresa.McMillan@Ontario.ca

Grounds / Motifs :

1. Previously issued non compliance as a Voluntary Plan of Correction on February 27, 2014.

1. The licensee did not ensure that, a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

(A) A review of resident #004's clinical records indicated weekly skin and wound assessments for altered skin integrity during a month in 2014 for an extremity. A new weekly skin assessment and dietary referral was completed during that time for a different skin integrity issue for resident #004. There were no further weekly skin assessments using a clinically appropriate assessment instrument designed for skin and wound assessment for these alterations in skin integrity. Two weeks later a nursing progress note indicated the second skin integrity issue had been resolved.

During that month, three progress notes identified the first altered skin integrity issue using varying descriptors with interventions required. The dietary assessment conducted the following month referred to an alteration in skin integrity of the extremity with a different descriptor. An additional month later, a quarterly skin assessment was completed and indicated altered skin integrity however there were no further weekly skin assessments on file.

An interview with the DOC confirmed the home did not ensure that when resident #004 exhibited altered skin integrity they received weekly skin

assessments using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

(B) Resident #026 developed altered skin integrity to an extremity during a month in 2014. One month later registered staff noted that the skin integrity issue had healed. Two weeks later, registered staff noted that resident #026 had the same altered skin integrity issue to the same area as two weeks earlier. Inspection of all health records during this time frame for resident #026 indicated that there were no further skin assessments of the resident's extremity for a period of one month following the identification of the more recent altered skin integrity. Staff and the ADOC confirmed that weekly assessments should have been conducted on this altered skin integrity until the wound was noted as being healed. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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