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
Sep 21, 2018	2018_607523_0023	005945-18	Resident Quality Inspection

Licensee/Titulaire de permis

Craigwiel Gardens
221 Main Street R. R. #1 AILSA CRAIG ON N0M 1A0

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

Craigholme
221 Main Street, R.R. #1 AILSA CRAIG ON N0M 1A0

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

ALI NASSER (523), INA REYNOLDS (524), JOANNA WHITE (727), MIKO HAWKEN (724), NATALIE MORONEY (610), RHONDA KUKOLY (213), TERRI DALY (115)

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 4, 5, 6, 7, 10, 11, 12, 13 and 14, 2018.

The following intakes were completed within this inspection:

Critical Incident Log #005889-18 / CI 2622-000002-18 related to outbreak in the home.

Complaint Log #007259-18 / IL-56391-LO related to staffing shortages and specific care concerns.

Complaint Log #016060-18 / IL-57696-LO related to staffing shortages and specific care concerns.

Complaint Log #024000-18 / IL-59510-LO / IL-59537-LO related to specific care concerns.

Complaint Log #024665-18 / IL59729-LO related to specific care concerns.

Follow-up Log #009989-18 for Compliance Order (CO) #001 from Complaint Inspection #2018_605213_0005 related to the plan of care for residents.

Follow-up Log #009991-18 for Compliance Order (CO) #002 from Complaint Inspection #2018_605213_0005 related to sufficient staffing.

Follow-up Log #009992-18 for Compliance Order (CO) #003 from Complaint Inspection #2018_605213_0005 related to meal and snack services.

Follow-up Log #009993-18 for Compliance Order (CO) #004 from Complaint Inspection #2018_605213_0005 related to the home's complaint process.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Acting Director of Care, Office Assistant, Registered Physiotherapist, Hairdresser, Food Services Director, Environmental Services Manager, Cook, Physiotherapy Assistant, Registered Dietitian, Scheduling Clerk, Activity Aide, three Dietary Aides, 10 Registered Nurses, 12 Personal Support Workers, five family members, Resident and Family Council representatives and over 40 residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack services, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home and various meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #004	2018_605213_0005	523
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_605213_0005	115
O.Reg 79/10 s. 71. (3)	CO #003	2018_605213_0005	524

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written staffing plan (including the back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work); for the programs including Personal Care, Bathing, Activities of Daily Living, Bedtime and Rest Routines; provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The Ministry of Health and Long-Term Care received two complaints related to concerns about the home being short staffed, including multiple care concerns.

Follow-up to CO #002 issued in inspection #2018_605213_0005: The licensee must be compliant with s. 31(3) of O. Reg 79/10 and had a compliance date that had been amended for July 31, 2018.

A review of the "Staffing Planning" policy with a revised date of April 2017 was completed. The daily pattern unit included:
"Days:
Registered Nurse (RN) – 1
Registered Nurse (RN) – (10-6)-1

Registered Practical Nurse (RPN) – 3
Personal Support Worker (PSW) – 9
Evenings:
Registered Nurse – 1
Registered Practical Nurse – 3
Personal Support Worker - 9
Nights:
Registered Nurse – 1
Registered Practical Nurse – 0
Personal Support Worker – 3"

A review of the homes' audit report "August Report of Missing Shifts" showed that from August 1, 2018 to August 31, 2018, the home had 141 planned staff shifts that did not meet the homes compliment for the staffing plan.

A review of an email provided by the Administrator showed the following staffing lines that remained opened:

"One Temporary Part Time PSW –1 Position (filling other temporary positions)
Three full time evening PSW lines"

Interview with the Staff Unit Coordinator said that they also have one RN 10-6 line open.

Part a) of the order was that the home was to ensure that all residents received bi-weekly bathing at a minimum by the method of their choice and to ensure bathing was documented.

The home's bath schedules and the Point of Care documentation for bathing completed for a specific period of time was reviewed in PCC by the inspector showed that a specific number of residents showed no documentation that a bath was provided as required.

The home's bathing policy dated effective November 2013, revision Mar 2016, indicated: "All residents will be bathed twice per week, by method of their choice on a regularly scheduled day".

During an interview a specific resident said that they had not been in the bath since being admitted to the home and at times had gone two weeks without receiving any type of

bathing. The resident also felt that the home was short staffed all the time and was not receiving their bathing preference.

A specific PSW told inspector during an interview they are often short PSW's and they they have not been able to provide the residents' scheduled choice of bathing.

Director of Care said that the specific resident was not bathed according to their preference.

The inspector reviewed the contingency plan with the Administrator, they said that whey we were short 5 PSWs we would have to reschedule bathing and that "if we knew we were going to be short, we try to reschedule the baths" however this was not occurring as they could not complete the regular staffing on a day to day basis, to have extra stay scheduled to complete make up baths.
The "Staffing Contingency Plan" directed staff that "bed baths" were to be offered to residents remaining on the bath list, which was not in line with the legislation when short 3 or 4 PSW's, and there was no documented plan in the contingency plan when short 5 PSW's for bathing.

On a certain date the Administrator said that staff know by exclusion that everyone was a bath unless it says different on the bath sheet.

The Administrator acknowledged that there was no corrective action completed when the bath audits had been completed and the resident's that had been identified with not having bi-weekly bathing. The Administrator said that they expected the resident would receive bi-weekly baths according to the their preferences and would be documented in POC however this was not occurring. Administrator also acknowledge that the bathing choice should be part of the plan of care for the specific resident and was not, and that the resident had not been receiving baths as per their preference.

During an interview a specific resident said that they were scheduled for and wanted to have a specific type of bathing on specific days but was only receiving the specific type of bath every two weeks.
The Day bath and Evening schedule posted at the nursing station identified the resident was scheduled for the specific type of baths on the specific days.

Record review of bathing documentation in PCC for a specific period on time indicated baths were not completed on six out of 10 occasions.

The home's bathing policy dated and effective November 2013, revision Mar 2016, indicated: "All residents will be bathed twice per week, by method of their choice on a regularly scheduled day".

In an interview a specific Personal Support Worker (PSW) shared that when a resident missed a scheduled bath, the Point of Care system in PCC would flag the missed bath, and the resident would be offered a bath on another day.

In an interview the Acting DOC and the Inspector reviewed the documentation related to baths in PCC for the resident. The Acting DOC agreed that the resident was not provided baths on the specific dates as per the resident's choice.

Part b) of the order was that the home was to make sure that sleep and rest patterns were enforced.

- Review of documentation from POC that flows into PCC showed that a specific resident's sleep and rest choices were not identified in the resident's plan of care.
-A specific resident's rest and sleep choices were not identified as part of the plan of care. And POC documentation showed that the resident was awake seven times before a specific time and received certain care.
- A specific resident's had no identified sleep and rest preferences in plan of care review.
-A specific resident received care 12 times before a certain time that was specified in the the plan of care.

On a certain date the Point of Care "Shift Dashboard" in Point Click Care (PCC) was reviewed, specifically, the "Alerts Triggered in the last 24 hours". The documentation showed that a specific number of residents were documented as given HS care by night staff. A review of the sleep and rest audits completed in the home did not identify what time preference the residents had for waking up in the morning and going to bed at night.

A review of the plan of care for those identified resident's showed no preferences for sleep and rest.

During an interview the Administrator said that they had created audits for sleep and rest but there was no corrective action completed and that the home failed to identify sleep and rests preference in the individualized plan of care.

Part h) of the order was to ensure that the home developed and implemented an auditing process to ensure that all residents sleep and rest routines are adhered to, that all residents receive two baths per week by the method of their choice.

The MOHLTC had received a complaint on a certain dated regarding “staff shortage” and “care” that was not being provided to residents. A specific staff member during an interview stated that they reported their concerns to their manager but felt very concerned for the resident’s that were not provided care. The staff member said that on a specific date approximately 20 residents had been in a specific common area of the home for a specific period of time with one staff member present.

The Director of Food Services confirmed that the home had been directed to keep residents in the specific common area on that date by the Administrator. Director of Food services further explained that a specific Activity Aide was directed to stay in the common area because they didn’t have enough nursing staff to get the residents back and forth to their rooms. The Director of Food Services said "The Dietary Aide brought their concerns to me as I was told a specific resident was in the same position from breakfast till lunch." “My concern was the paper plates going out, because they were so short of nursing staff, they didn’t have enough staff to get them all fed, breakfast didn’t get finished until 1030 that day”. Director of Food Service also had concerns that food and fluids were not being documented accurately or possibly not meeting the resident’s nutritional intake needs.

A specific Activity Aide showed an inspector that on a specific date they had 16 residents in a program in the common area and another date they had 43 residents in a program in the dining. The Activity Aide said specific residents did not leave the common area from breakfast till after lunch.

A clinical record review for specific residents showed that they required support from staff for toileting needs and there was no documentation during the specific period of time that the residents care needs for toileting were provided and there was no completed documentation that oral care had been provided twice a day.

A review of the home’s policy entitled “Medical Records Documentation” with a revision date of March 2016, stated Charting Procedure: "The following information shall be documented in the electronic medical record: Daily care documentation via Point of Care System".

Administrator acknowledge that the specific residents required staff support for care and that there was no documented evidence that the care was provided to the residents.

The licensee has failed to ensure that the written staffing plan and the back-up plan for nursing and personal care staffing provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The home was operating on their contingency plan 97 percent of the time (38/39 days) for a specific period of time. At times the home was working up to 5/9 PSW lines, and 1/3 RPN lines on a day shift which was what the plan allotted. During that time, residents did not receive two baths per week, daily documentation was not completed, residents were being washed and dressed before a certain time, and evening care for numerous residents was note completed till after a specific time. Numerous resident were being left in a common area after breakfast till after lunch in large groups with one activity aide on at least two identified dates and the audits for bathing, sleep and rest were not implemented with corrective actions and the plan of care did not specify the resident choice of bathing or preference for sleep and rest times suitable for the time and day and the home remains not fully staffed.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section of the Act that included:
Compliance Order issued on May 24, 2018(A1), (2018_605213_0005 (A1)) [s. 31. (3)]

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. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with this Act and every order made under this Act 2007, c. 8, s. 195 (12).

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2018_605213_0005(A1) served on May 24, 2018(A1), with a compliance date of July 06, 2018(A1).

The licensee was ordered to do the following:
"The licensee must be compliant with s.6 (7) of the LTCHA.
Specifically, the licensee shall ensure the following:
a) Ensure resident #006, and any other resident, when indicated in the plan of care, have the number of side rails in use as specified in the plan of care.
b) Ensure that all nursing staff receive training related to the use of bed rails as per residents' plans of care. Attendance records for this training are to be maintained.
c) The home will develop and implement an auditing process to ensure that resident #006 specifically, and any resident who uses bed rails, have the number of side rails in use as specified in the plan of care. Records for these audits are to be maintained."

The licensee failed to complete step b of the Compliance Order .

During an interview with the Acting Administrator, the inspector requested the education and training information related to CO #001. The home provided a list of staff, which was confirmed as being all nursing staff. The document with a hand written title at the top of it Bed Rail / Bed Entrapment / Tray Service / Complaint Process Training was reviewed in the Acting Administrator's presence. It showed a list of staff, some that included the staff's signature which meant they had completed the education. The inspector asked if the staff

without signatures currently worked at the home and the Acting Administrator took a pencil and wrote LOA (leave of absence) or resigned by some of the staff names. The Acting Administrator acknowledged that the education was on-going but that the staff without a signature had not completed the training per the CO.

A review of the education documents provided revealed that attendance records for this training were maintained but showed that 21 out of 58 or 36.3% of staff did not receive the training related to the use of bed rails as per residents' plans of care.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 2 and was identified as a pattern. The home had a level 2 as there was unrelated non-compliance in this subsection of the legislation. [s. 101. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

During stage 1 of the RQI, staff interviews showed that specific residents had a certain personal care device. Observations on a certain date showed that both of these residents had that specific personal care device.

Record reviews of physician's orders, Treatment Administration Records and plans of care were reviewed in Point Click Care (PCC) for the specific residents.

The physician's orders and TAR for the residents indicated to change the personal care device at a specific period of time but did not indicate the type or size of device to be used. The physician's orders also indicated to apply the device one time PRN and to call MD. The care plan did not indicate the resident had the specific device, the size or type and did not include any direction for staff regarding interventions or monitoring when device was applied.

In an interview the Acting Director of Care agreed that there was no direction to

registered staff related to the type and size of the device the staff were to use in the physician's orders, TAR or care plan and that this information should be included in these areas. The Acting DOC also agreed that there should also be direction for Personal Support Workers in the plan of care regarding the use of the device, interventions and monitoring when applied and this direction was not present in the care plan or Kardex for the specific residents.

The licensee has failed to ensure that the written plan of care for specific residents set out clear directions to staff and others who provided direct care to the resident related to the use of a certain personal care device. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During the inspection a specific family member said that they had specific concerns with specific aspects of personal care provided to the resident.

A review of the progress notes showed that the family had brought concerns to a Registered Practical Nurse on a specific date regarding those care concerns.

A record review of the written plan of care showed that the resident was on a specific prompt care plan. However the plan was not clear in the directions to indicate specified times to implement this plan for the staff to follow.

The licensee did not ensure that the written care plan for a specific resident sets out clear directions for staff to follow. [s. 6. (1) (c)] (724) [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A clinical record review for a specific resident showed that on a specific day the resident was was using a personal device in the hallway when they fell to the floor.

A clinical record review for the resident showed that a specific reassessment showed that the resident used the personal device.

In an interview, a Physiotherapist (PT) said that the resident was dependent on the use of this personal device for mobility.

Clinical record review for the resident showed that a certain assessment showed that the resident was dependent on using the personal device for mobility.

Clinical record review for the resident’s plan of care showed no indication that the resident needed the personal device.

In an interview an RN said that the resident has been using the personal device for a long time, RN reviewed the plan of care and said that there was no indication that the resident needed the personal device for mobility.

In an interview the ADOC reviewed the clinical record and said that the plan of care was not based on the assessment of the resident.
The ADOC said that it was the expectation that the plan of care would be based on an assessment of the resident and the resident's needs and preferences.

The licensee has failed to ensure that the resident's plan of care was based on an assessment of the resident need. [s. 6. (2)]

4. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

In an interview a specific PSW said that a specific resident's had a certain preference related to their bed routine.

In an interview a specific RN stated the resident's preference. The RN reviewed the plan of care, it showed no interventions or information that reflected the resident’s preference.

In an interview the ADOC reviewed the resident's assessment and plan of care, they said that the resident's plan of care was not based on their preference. ADOC said that the plan of care should have been based on the preference of the resident.

The licensee has failed to ensure that the resident's plan of care was based on an assessment of the resident preference specific to bed routines. [s. 6. (2)]

5. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

a) A review of a specific resident's clinical record indicated the resident was assessed at a specific nutritional risk by the Dietitian related to a chronic disease related to intake. The home had a system to monitor the food and fluid intake of resident's with identified risks related to nutrition and hydration on Point of Care (POC) as required by legislation. Record review of the plan of care directed staff to monitor and record the resident's percentage of meal intake in the task flow sheets on POC. There were also options available to indicate if the resident refused or was not available.

A review of the resident's POC task flow sheet documentation for a specific period of time indicated that there were instances where no documentation occurred.

b) A review of a specific resident's clinical record indicated the resident was assessed at a specific nutritional risk related to specific diagnosis. Care plan goals indicated the resident was to have specific food and fluid intake provided from meals and snacks, as monitored on POC.

A review of the resident's POC task flow sheet documentation for a specific period of time indicated that there were instances where no documentation occurred.

c) A review of a specific resident's clinical record indicated the resident was assessed at a specific nutritional risk related to specific difficulties. The care plan goal stated the resident was to a specific food and fluid intake provided from meals and snacks, as monitored on POC.

A review of the resident's POC task flow sheet documentation for a specific period of time indicated that there were instances where no documentation occurred.

During an interview the Acting Administrator acknowledged documentation was missing on the POC meal task record for the specific residents and that the expectation was that Personal Support Workers were to document intake after the provision of meals so that the effectiveness of the goals and interventions could be assessed.

The licensee failed to ensure that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
The written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident
The plan of care was based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, or system, the plan, policy or system was complied with.

In accordance with O. Reg. 79/10, s 48. (1) 1 the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, developed and implemented in the home.

A review with the ADOC of the home's policy subject Fall Prevention Program: Roles and Responsibility, revised date July 2016 showed that (RN and RPN: initiates plan of care to address residents identified as high risk and implements high risk strategies such as a visual management system, bed assigned is close to the nursing station if possible, high fall-risk magnet/signage by bed) .

A clinical record review for a specific resident showed that on a certain date the resident had a fall.

ADOC and inspector reviewed the resident's clinical record. Plan of care showed that resident was at a certain risk for falls, they said that the resident would have the leaf signage on their board in the room.

ADOC and inspector observed the resident's room and there was no signage posted for the resident. They said that the homes policy was not implemented for this resident as the resident's risk for falls signage was not posted. [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 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, or system, the plan, policy or system was complied with., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during the RQI showed that specific residents' rooms had windows that opened to the outside more than 15 centimetres:

In an interview the Environmental Manager said that they did not have a process in place to ensure the windows in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Inspector and the Environmental Manager toured the specified sample rooms and observed windows opened more than 15 centimetres.

Environmental Manager said that they were going to complete an audit on all the windows and ensure that windows could not open more than 15 centimetres. [s. 16.]

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 window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs.

During stage 1 of the Resident Quality Inspection (RQI), staff interviews showed that specific residents had specific interventions. Observations showed that all of these residents had that specific intervention in place.

In an interview the Acting Director of Care (DOC) shared that it was their role to complete the admission process for new residents in the home. The inspector and the Acting DOC reviewed the physician's orders for the specific residents. The inspector noted that all three residents have a physician's order that directed staff to complete this intervention PRN. The Acting DOC said that this was a medical directive, so all residents had that order. The inspector asked how medical directives were ordered. The Acting DOC shared a blank medical directives sheet that was double sided and included multiple orders including medications, treatments, blood work, etcetera, the medical directive blank sheet was already signed by the physician with no resident name or date or allergies indicated. The inspector asked if that form was a copy, and the Acting DOC said yes, they have a supply of signed copies that they use for residents and just fill in the resident's name at the time of their admission. The inspector asked if the medical directives were individualized for residents, and they responded no. The inspector asked, if all residents have a medical directive for a specific interventions even if they did not require that intervention, and the Acting DOC responded yes.

In an interview the Acting Administrator agreed that the medical directives were not individualized for residents.

A record review of the "Resident Specific Medical Directives" policy, dated revised October 2016 was conducted. The procedure stated: "Upon admission of each resident a Medical Directive will be completed by the attending physician, signed and dated. The Attending Physician is required to identify by his/her initials each medical directive that is appropriate and approved for the specific resident".

The licensee has failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs for the specific residents . [s. 81.]

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 no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Observations during the inspection with the Environmental Services Manager showed corrosion and chips in specific bathroom sinks and/or rust coloured stains in the sink surface and around the base of certain toilets in specific resident bathrooms.

The Environmental Services Manager (ESM) on a certain date acknowledged the need for sink and toilet replacements in identified resident bathrooms. ESM indicated that it was the home's expectation that sinks and toilets were maintained and kept free from corrosion and that this had been ongoing and was a work in process. [s. 90. (2) (d)]

Issued on this 3rd day of October, 2018

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) :	ALI NASSER (523), INA REYNOLDS (524), JOANNA WHITE (727), MIKO HAWKEN (724), NATALIE MORONEY (610), RHONDA KUKOLY (213), TERRI DALY (115)
Inspection No. / No de l'inspection :	2018_607523_0023
Log No. / No de registre :	005945-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 21, 2018
Licensee / Titulaire de permis :	Craigwiel Gardens 221 Main Street, R. R. #1, AILSA CRAIG, ON, N0M-1A0
LTC Home / Foyer de SLD :	Craigholme 221 Main Street, R.R. #1, AILSA CRAIG, ON, N0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gemma Nott

To Craigwiel Gardens, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_605213_0005, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with s. 31(3) of O. Reg 79/10.
Specifically, the licensee shall ensure the following:

a) Ensure that all residents' bathing preference is documented in the plan of care and all residents are bathed at a minimum twice a week by the method of their choice and bathing is documented.
b) Ensure that the sleep and rest patterns and preferences for all residents are documented in the plan of care and adhered to as per the residents' individual plans of care.
c) Ensure that residents are not left in the dining room after meals and ensure that the care set out in the plan of care was provided and documented.
d) Develop and implement an auditing process and corrective action plan to ensure that all residents' sleep and rest routines are identified in the plan of care and adhered to, that all residents' bathing method of choice is identified in the plan care and residents receive two baths per week by the method of their choice. Records for these audits are to be maintained.
e) Evaluate and revise the home's staffing plan and the contingency plan on a monthly basis. The revised plans will be implemented and include issues, short and long term goals, action items, responsible persons, target dates, evaluation and resolved dates. This monthly review and revision will continue until the home is consistently, fully staffed, according to their staffing plan. The evaluation and revision and the dates completed will be documented.
f) Ensure that all staff are educated on the home's documentation policy including documentation in Point of Care and Point Click Care.

Grounds / Motifs :

1. The licensee has failed to ensure that the written staffing plan (including the back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work); for the programs including Personal Care, Bathing, Activities of Daily Living, Bedtime and Rest Routines; provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The Ministry of Health and Long-Term Care received two complaints related to concerns about the home being short staffed, including multiple care concerns.

Follow-up to CO #002 issued in inspection #2018_605213_0005: The licensee must be compliant with s. 31(3) of O. Reg 79/10 and had a compliance date that had been amended for July 31, 2018.

A review of the "Staffing Planning" policy with a revised date of April 2017 was completed. The daily pattern unit included:
"Days:
Registered Nurse (RN) – 1
Registered Nurse (RN) – (10-6)-1
Registered Practical Nurse (RPN) – 3
Personal Support Worker (PSW) – 9
Evenings:
Registered Nurse – 1
Registered Practical Nurse – 3
Personal Support Worker - 9
Nights:
Registered Nurse – 1
Registered Practical Nurse – 0
Personal Support Worker – 3"

A review of the homes' audit report "August Report of Missing Shifts" showed that from August 1, 2018 to August 31, 2018, the home had 141 planned staff shifts that did not meet the homes compliment for the staffing plan.

A review of an email provided by the Administrator showed the following staffing lines that remained opened:

"One Temporary Part Time PSW –1 Position (filling other temporary positions)
Three full time evening PSW lines"

Interview with the Staff Unit Coordinator said that they also have one RN 10-6 line open.

Part a) of the order was that the home was to ensure that all residents received bi-weekly bathing at a minimum by the method of their choice and to ensure bathing was documented.

The home's bath schedules and the Point of Care documentation for bathing completed for a specific period of time was reviewed in PCC by the inspector showed that a specific number of residents showed no documentation that a bath was provided as required.

The home's bathing policy dated effective November 2013, revision Mar 2016, indicated: "All residents will be bathed twice per week, by method of their choice on a regularly scheduled day".

During an interview a specific resident said that they had not been in the bath since being admitted to the home and at times had gone two weeks without receiving any type of bathing. The resident also felt that the home was short staffed all the time and was not receiving their bathing preference.

A specific PSW told inspector during an interview they are often short PSW's and they they have not been able to provide the residents' scheduled choice of bathing.

Director of Care said that the specific resident was not bathed according to their preference.

The inspector reviewed the contingency plan with the Administrator, they said that whey we were short 5 PSWs we would have to reschedule bathing and that "if we knew we were going to be short, we try to reschedule the baths" however this was not occurring as they could not complete the regular staffing on a day to day basis, to have extra stay scheduled to complete make up baths.
The "Staffing Contingency Plan" directed staff that "bed baths" were to be offered to residents remaining on the bath list, which was not in line with the legislation when short 3 or 4 PSW's, and there was no documented plan in the contingency plan when short 5 PSW's for bathing.

On a certain date the Administrator said that staff know by exclusion that everyone was a bath unless it says different on the bath sheet.

The Administrator acknowledged that there was no corrective action completed when the bath audits had been completed and the resident's that had been identified with not having bi-weekly bathing. The Administrator said that they expected the resident would receive bi-weekly baths according to the their preferences and would be documented in POC however this was not occurring. Administrator also acknowledge that the bathing choice should be part of the plan of care for the specific resident and was not, and that the resident had not been receiving baths as per their preference.

During an interview a specific resident said that they were scheduled for and

wanted to have a specific type of bathing on specific days but was only receiving the specific type of bath every two weeks.
The Day bath and Evening schedule posted at the nursing station identified the resident was scheduled for the specific type of baths on the specific days.

Record review of bathing documentation in PCC for a specific period on time indicated baths were not completed on six out of 10 occasions.

The home's bathing policy dated and effective November 2013, revision Mar 2016, indicated: "All residents will be bathed twice per week, by method of their choice on a regularly scheduled day".

In an interview a specific Personal Support Worker (PSW) shared that when a resident missed a scheduled bath, the Point of Care system in PCC would flag the missed bath, and the resident would be offered a bath on another day.

In an interview the Acting DOC and the Inspector reviewed the documentation related to baths in PCC for the resident. The Acting DOC agreed that the resident was not provided baths on the specific dates as per the resident's choice.

Part b) of the order was that the home was to make sure that sleep and rest patterns were enforced.

- Review of documentation from POC that flows into PCC showed that a specific resident's sleep and rest choices were not identified in the resident's plan of care.
-A specific resident's rest and sleep choices were not identified as part of the plan of care. And POC documentation showed that the resident was awake seven times before a specific time and received certain care.
- A specific resident's had no identified sleep and rest preferences in plan of care review.
-A specific resident received care 12 times before a certain time that was specified in the the plan of care.

On a certain date the Point of Care "Shift Dashboard" in Point Click Care (PCC) was reviewed, specifically, the "Alerts Triggered in the last 24 hours". The documentation showed that a specific number of residents were documented as

given HS care by night staff. A review of the sleep and rest audits completed in the home did not identify what time preference the residents had for waking up in the morning and going to bed at night.

A review of the plan of care for those identified resident's showed no preferences for sleep and rest.

During an interview the Administrator said that they had created audits for sleep and rest but there was no corrective action completed and that the home failed to identify sleep and rests preference in the individualized plan of care.

Part h) of the order was to ensure that the home developed and implemented an auditing process to ensure that all residents sleep and rest routines are adhered to, that all residents receive two baths per week by the method of their choice.

The MOHLTC had received a complaint on a certain dated regarding "staff shortage" and "care" that was not being provided to residents. A specific staff member during an interview stated that they reported their concerns to their manager but felt very concerned for the resident's that were not provided care. The staff member said that on a specific date approximately 20 residents had been in a specific common area of the home for a specific period of time with one staff member present.

The Director of Food Services confirmed that the home had been directed to keep residents in the specific common area on that date by the Administrator. Director of Food services further explained that a specific Activity Aide was directed to stay in the common area because they didn't have enough nursing staff to get the residents back and forth to their rooms. The Director of Food Services said "The Dietary Aide brought their concerns to me as I was told a specific resident was in the same position from breakfast till lunch." "My concern was the paper plates going out, because they were so short of nursing staff, they didn't have enough staff to get them all fed, breakfast didn't get finished until 1030 that day". Director of Food Service also had concerns that food and fluids were not being documented accurately or possibly not meeting the resident's nutritional intake needs.

A specific Activity Aide showed an inspector that on a specific date they had 16 residents in a program in the common area and another date they had 43

residents in a program in the dining. The Activity Aide said specific residents did not leave the common area from breakfast till after lunch.

A clinical record review for specific residents showed that they required support from staff for toileting needs and there was no documentation during the specific period of time that the residents care needs for toileting were provided and there was no completed documentation that oral care had been provided twice a day.

A review of the home's policy entitled "Medical Records Documentation" with a revision date of March 2016, stated Charting Procedure: "The following information shall be documented in the electronic medical record: Daily care documentation via Point of Care System".

Administrator acknowledge that the specific residents required staff support for care and that there was no documented evidence that the care was provided to the residents.

The licensee has failed to ensure that the written staffing plan and the back-up plan for nursing and personal care staffing provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The home was operating on their contingency plan 97 percent of the time (38/39 days) for a specific period of time. At times the home was working up to 5/9 PSW lines, and 1/3 RPN lines on a day shift which was what the plan allotted. During that time, residents did not receive two baths per week, daily documentation was not completed, residents were being washed and dressed before a certain time, and evening care for numerous residents was note completed till after a specific time. Numerous resident were being left in a common area after breakfast till after lunch in large groups with one activity aide on at least two identified dates and the audits for bathing, sleep and rest were not implemented with corrective actions and the plan of care did not specify the resident choice of bathing or preference for sleep and rest times suitable for the time and day and the home remains not fully staffed.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 3 as it related to most residents in the home. The home had a level 3 history of one or more related non-compliance with this section of the Act that included:

Compliance Order issued on May 24, 2018(A1), (2018_605213_0005 (A1)) [s. 31. (3)] (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2018

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be compliant with s.101(3) of the LTCHA.
Specifically, the licensee shall ensure that all nursing staff receive training related to the use of bed rails as per residents' plans of care. Attendance records for this training are to be maintained.

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with this Act and every order made under this Act 2007, c. 8, s. 195 (12).

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2018_605213_0005(A1) served on May 24, 2018(A1), with a compliance date of July 06, 2018(A1).

The licensee was ordered to do the following:
"The licensee must be compliant with s.6 (7) of the LTCHA.
Specifically, the licensee shall ensure the following:
a) Ensure resident #006, and any other resident, when indicated in the plan of care, have the number of side rails in use as specified in the plan of care.
b) Ensure that all nursing staff receive training related to the use of bed rails as per residents' plans of care. Attendance records for this training are to be maintained.
c) The home will develop and implement an auditing process to ensure that resident #006 specifically, and any resident who uses bed rails, have the number

of side rails in use as specified in the plan of care. Records for these audits are to be maintained."

The licensee failed to complete step b of the Compliance Order .

During an interview with the Acting Administrator, the inspector requested the education and training information related to CO #001. The home provided a list of staff, which was confirmed as being all nursing staff. The document with a hand written title at the top of it Bed Rail / Bed Entrapment / Tray Service / Complaint Process Training was reviewed in the Acting Administrator's presence. It showed a list of staff, some that included the staff's signature which meant they had completed the education. The inspector asked if the staff without signatures currently worked at the home and the Acting Administrator took a pencil and wrote LOA (leave of absence) or resigned by some of the staff names.
The Acting Administrator acknowledged that the education was on-going but that the staff without a signature had not completed the training per the CO.

A review of the education documents provided revealed that attendance records for this training were maintained but showed that 21 out of 58 or 36.3% of staff did not receive the training related to the use of bed rails as per residents' plans of care.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 2 and was identified as a pattern. The home had a level 2 as there was unrelated non-compliance in this subsection of the legislation. [s. 101. (3)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 25, 2018

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 21st day of September, 2018

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 : Ali Nasser

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