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
Jul 23, 2014	2014_214146_0014	H-000831-14	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

CRESCENT PARK LODGE
4 Hagey Avenue, Fort Erie, ON, L2A-5M5

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

BARBARA NAYKALYK-HUNT (146), ROBIN MACKIE (511), ROSEANNE WESTERN (508)

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): July 9, 10, 11, 14, 15, 16, 17, 18, 21, 2014

This inspection was conducted concurrently with Follow-up Inspection H-000058-14, Complaint Inspection H-000376-14 and Critical Incident inspections H-000647-14, H-000634-14. Findings for these inspections are included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Dietitian (RD), Environmental Services Manager (ESM), Food Services Manager (FSM), Nursing Office Assistant, Resident Assessment Instrument (RAI) Coordinator, Registered staff, Personal Support Workers (PSW's), dietary staff, housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents, reviewed meeting minutes, complaint forms, internal investigation notes, resident health records, staffing schedules, cleaning schedules, manufacturer's instructions and policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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, (c) clear directions to staff and others who provide direct care to the resident.

(A) A resident's care plan that the direct care staff referred to for directions did not provide clear directions to staff. The care plan directed staff to provide a specific type of intervention and, in another area of the care plan, to provide a different type of intervention. It was confirmed by staff that the directions were not clear. (508)

(B) A resident's care plan available to the direct care staff directed staff to transfer the resident in a specific manner. The current electronic plan of care directed staff to use a different manner of transfer. Interview with the MDS-RAI coordinator confirmed the written plan of care did not provide clear directions to staff and others who provided direct care to the resident. (511)

(C) The care plan for a resident, under the focus of dressing, directed staff to provide a specific intervention. On the same care plan, under a different focus, the staff were directed that the resident did not use the intervention. The directions were conflicting. (146)

(D) A resident's care plan that the direct care staff referred to for direction in providing care to the resident did not provide clear directions to staff. No directions were provided related to responding to specific resident behaviours.
It was confirmed by the RAI Coordinator that the resident's plan of care did not provide clear directions to staff who provide care to the resident. [s. 6. (1) (c)]

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

(A) A resident was assessed by nursing in January 2013 in a Minimum Data Set (MDS) assessment as having a specific problem and was assessed as having the same problem again each quarter in April 2013, October 2013 and January 2014. Physician assessments during the same time frame indicated no problem. The RAI Coordinator confirmed that the resident did have the problem in January 2013 that cleared up and the remainder of the assessments were not collaborative.

(B) A resident's health record indicated that the resident had a specific problem. The assessment of the problem completed in April 2014 described the problem. An MDS assessment completed on the same date assessed the problem very differently. The inconsistent assessments were confirmed by the RAI coordinator.

(C) A resident's health record indicated that a certain treatment was provided for a specific problem in July 2014. In an RD assessment for the resident completed in July 2014, the RD stated the problem was resolved. However, the problem was observed to be present in July 2014 by the inspector. The assessments of the problem conflicted with each other.

(D) A resident's health record indicated a very specific assessment of a problem in April 2014. On the same date, an MDS assessment indicated a very different assessment of the problem. The assessments were not consistent with each other as confirmed by the RAI coordinator. [s. 6. (4) (a)]

3. The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

(A) In a family interview in July 2014, the substitute decision maker (SDM) of a resident stated that they had not been consulted or notified of a change in their family member's plan of care. The SDM had not been informed of the change in the plan of care and was concerned that the opportunity to participate fully in the plan of care was not provided to the SDM. This information was confirmed by the DOC.

(B) During a review of the complaint log, it was noted that the POA of an identified resident had complained in February 2014 that the POA had not been apprised of recent plan of care changes for the resident. The SDM of another identified resident lodged a similar complaint of not being notified of plan of care changes in September 2013. The DOC confirmed this information. [s. 6. (5)]

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

(A) A resident's plan of care directed staff to have a specific intervention in place. On a date in July 2014, the resident was observed without the intervention in place. Staff

confirmed that it should have been in place. (146)

(B) A resident's plan of care directed staff to provide a specific intervention. On a date in July 2014, the intervention was not implemented as confirmed by staff. (146)

(C) A resident's plan of care indicated that a specific intervention was required. On five days of this inspection the intervention was not provided as directed. This information was confirmed by staff. (146)

(D) A resident's plan of care identified the resident as a moderate nutritional risk and directed staff to provide specific intervention to moderate the risk. The intervention was not provided on a date in May 2014. The DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (511)

(E) A resident stated on three different occasions over several months that a specific intervention was not provided by staff. The DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (511)

5. The licensee did not ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

(A) A resident's current updated care plan was not made accessible to direct care staff. The kardex care plan did not contain the updated interventions as outlined in the electronic version of the care plan dated May 3, 2014. Interview with the 2 PSW's indicated they were unaware of the resident's present interventions, did not have access to electronic care plans and had to reference the hard copy kardex version of the care plan to find out about the resident's status.
The ADOC confirmed the home does not print the most recent electronic care plan and the direct care PSW's do not have convenient and immediate access to it.

(B) A resident was using an intervention which was documented on the electronic care plan accessible only to registered staff. The resident kardex that the front line staff have access to did not identify this intervention.
It was confirmed during an interview with the DOC that the staff that provided direct care to resident #021 did not have convenient and immediate access to the current care plan. (508) [s. 6. (8)]

6. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs change or care set out in the plan is no longer necessary.

(A) A resident was assessed by the staff as requiring a specific intervention A because of a condition which was diagnosed in November 2013. The plan of care for November 2013 and January 2014 directed staff to provide intervention B for the resident. The staff confirmed that the resident had received intervention C up until a month ago (mid-June) when they started to use intervention A. The plan of care was not revised to reflect the change in interventions until July 10, 2014. This information was confirmed by the DOC.

(B) A resident #034 had a change in condition in March 2014. The resident's plan of care was not reviewed or revised when the resident's condition and needs changed. The RAI Coordinator confirmed that the resident's plan of care was not reviewed or revised when the resident's care needs changed.(508) [s. 6. (10) (b)]

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 to ensure that: (1)(c)the plan of care sets out clear directions to staff and others who provide direct care to the resident; and (10)(b) the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
20. Every resident has the right to participate in the Residents' Council. 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: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

(A) A cognitively alert resident reported a situation where the resident's assessed needs were not met. Interview with the DOC confirmed some staff were not meeting the resident's needs and the staff had been re-instructed on the resident's care needs. (511)

(B) In May 2014, a resident reported a situation where assessed care needs were not met resulting in resident discomfort.
It was confirmed by the DOC that the resident was not cared for in a manner consistent with the resident's assessed needs. (508) [s. 3. (1) 4.]

2. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 20. Every resident has the right to participate in the Residents' Council.
(A) The home's Resident Council consists of ten residents who are appointed/suggested by the staff liaison and then voted onto the Council by the nine other residents on the Council. These 10 residents were the only residents who were allowed to vote on issues in Resident Council meetings. Other residents were allowed to attend the meetings but were not allowed a vote. Only the ten appointed/elected residents were allowed full participation on the Residents' Council. This information was confirmed by the staff liaison of the Resident Council. (146) [s. 3. (1) 20.]

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 following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was:
(b) complied with.

(A) In the home's skin care and wound policy CN-S-13-1, a wound care referral form CN-S-19-1 is to be completed and submitted to the Skin Care Coordinator when a Stage 2 wound is discovered. The forms were not found for two residents. The ADOC confirmed that the forms are not used.

(B) A resident stated a staff member had treated the resident roughly when providing resident care in May 2014. A review of the home's Abuse-Prevention, Reporting and Eliminating of Abuse and Neglect policy # CA-05-37-1 confirmed physical abuse is defined to include rough handling of a resident. The home's policy #CA-05-37-1 stated that the attending physician was to be contacted to arrange for a medical assessment in cases of or suspected cases of physical or sexual abuse. The DOC confirmed the allegation of rough handling by the resident constituted physical abuse as per their policy and the physician was not notified, nor the resident physically assessed after the incident. (511) [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(b) complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure the resident was protected from abuse by the licensee or staff.

A cognitively alert resident stated in an interview that a staff member had treated the resident roughly when providing personal care in May 2014. A record review confirmed the home was notified by the resident of the incident and the home completed an internal investigation. The DOC confirmed the staff member had a recent and previous incident of rough care with a resident. [s. 19. (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 that residents are protected from abuse by anyone and that the residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that when there were reasonable grounds to suspect that there was misuse or misappropriation of resident's money that the suspicion and the information upon which it was based on was immediately reported to the Director.

A resident reported in May 2014, that a sum of money was taken from the resident's room. The home investigated the complaint, however the missing money was not found. The home did not report the missing money to the Director.
It was confirmed by the Administrator that this incident of missing money was not reported to the Director. [s. 24. (1) 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 a person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director
4. misuse or misappropriation of resident's money, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

A resident stated in an interview that a staff member had treated the resident roughly when providing resident care in May 2014. A record review confirmed the home completed an internal investigation and verified the complaint.
The DOC confirmed that the appropriate police force was not notified of the alleged and suspected abuse of a resident. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may have constituted a criminal offence, to be implemented voluntarily.

WN #7: 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).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident’s condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident’s condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were 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.

(A) In July 2014, a resident was observed to be sitting in a chair with a restraining device. The manufacturer's instructions to apply the device snugly were not followed. This observation was confirmed by staff present.

(B) In July 2014, a resident was observed sitting in a wheelchair with a restraining device applied. It was observed that device was not applied as per the manufacturer's instructions. This observation was confirmed by the staff present. [s. 110. (1) 1.]

2. The licensee did not ensure that the resident's condition was reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident, or a member of the registered nursing staff, at least every eight hours, and at any other time on the resident's condition or circumstances.

A resident was restrained. In February 2014 and March 2014 there were 24 shifts where the registered staff did not evaluate this restraint. In the first two weeks of July, there were five shifts when the registered staff did not evaluate this restraint.
It was confirmed by the DOC that the restraint was not evaluated every eight hours by the registered staff. [s. 110. (2) 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 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, to be implemented voluntarily.

WN #8: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection control program.

(A) It was observed in July 2014, that housekeeping staff were cleaning the bathroom of a resident infected with an Antibiotic Resistant Organism (ARO) without using the required personal protective equipment. Personal protective equipment (PPE) was available outside of the resident's room.

(B) In July 2014 a PSW was observed in a room providing care to a resident with an ARO without PPE. The PPE was available outside of the resident's room.

(C) In July 2014, inspectors observed staff providing care to residents in two resident rooms that were identified as having an ARO. Both rooms had available PPE outside the rooms.
It was confirmed by registered staff that staff should have been wearing the required PPE. [s. 229. (4)]

2. The licensee did not ensure that residents admitted to the home were screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

A resident's paperwork indicated that the resident had tested positive for tuberculosis (TB) prior to admission to the home. Residents that test positive are screened for TB by a chest x-ray to confirm that the TB is not active. The clinical records indicated that the resident did not receive a chest x-ray for TB screening until a year later.
It was confirmed by the Resident Assessment Instrument Coordinator that the resident was not screened upon admission to the home for tuberculosis. [s. 229. (10) 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 that staff participate in the implementation of the infection control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary.

(A) During this inspection it was observed that the flooring in residents' rooms, particularly around the toilets, were discoloured and stained in more than 50% of the resident bathrooms. An interview with the interim Housekeeping and Laundry Manager indicated that the flooring's layer of wax in these areas were stripped due to the improper use of chemicals.

(B) Two shared residents' bathrooms had strong urine odours.

(C) It was observed in one resident room, on six days of this inspection, that the toilet seat was soiled with a yellow residue. A dark red matter was also observed on the resident's bathroom wall.
An interview with the interim Housekeeping and Laundry Manager confirmed that these identified areas were not kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

(A) During this inspection, it was observed that there were several areas throughout the home where the floors were damaged and stained.
(i) In the bathroom used by residents in two rooms, the vinyl baseboard was partially pulled off.
(ii) In four rooms the flooring was noted to be damaged and in some of these damaged areas, a gritty, black matter was visible.
(iii) The dining room floor was gouged in an area where residents walk to and from their tables.
(iv) 10 out of 24 resident rooms had gouges noted on the walls as well as in the main lounge and the resident sitting area near the nursing station.
(v) The Supply Room door and seven of the resident's rooms were gouged with paint chipping.
The Environmental Supervisor confirmed that these areas identified required repair and maintenance. [s. 15. (2) (c)]

WN #10: 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) A resident health record, specifically the TAR, indicated that a condition had been noted and treated. No assessment of the condition was documented. The nurse who signed the TAR confirmed that an assessment had been completed at the time but not documented. [s. 30. (2)]

WN #11: 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 not ensured that 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.

(A) Staff and residents were interviewed related to the staffing complement meeting resident needs:
(i) The staffing scheduler confirmed that PSW hours were cut back on March 3, 2014 by 7.5 hours per day. 5.5 hours were eliminated from the day shift from 0600 to 1430. 2 hours were eliminated from the evening shift. Also on December 12, 2013, staff were advised that the first sick call of the shift would not be replaced. Recently that directive has been revised to not replace the sick call every other time.
PSW's interviewed stated that, as a result of not replacing the first sick call, they worked short at least 50% of the time and all weekends. A review of the work schedules for April, May and June 2014 with the scheduler revealed that staff actually worked short on either days and/or evenings 47% of the days in April, 68% of the days in May and 70% of the days in June, 2014. The schedule review confirmed that staff have worked short every weekend since April 12, 2014. These numbers were confirmed by the scheduler.
(ii) PSW #1 stated that bedside caregivers felt rushed all the time and were very stressed.
(iii) PSW #2 stated that meals are frequently served late; residents are not being put back to bed when they are tired; and on a weekend day shift when staff were short 2 persons, the beds did not get made.
(iv) A resident stated that the resident did not get oral care done sometimes for 2 days in a row because staff were so rushed.
(v) PSW #3 stated that they are not working short as many days since the inspection has started. PSW #3 stated that when short, the PSW does not give all personal care to the residents and leaves out mouth care and shaving. PSW #3 stated that residents do not get 2 baths per week consistently.
(vi) PSW's #4, 5 and 16 all stated that they work short at least half of their shifts.
(v) PSW #17 stated that resident baths do not get done if scheduled on a day when the bath person calls in. PSW #17 also stated that residents are not getting put back to bed when tired, especially after meals.
(vi) A resident stated that meals are consistently late by 20 minutes and the resident gets very hungry by the time the resident gets breakfast at 0930. A resident reported that the resident knew staffing was short again on the weekend because of the "chaos on the floor". Staff were rushing, stressed and yelling at each other down the hall. The

resident stated that the bells were ringing for a long time and it was very disturbing to residents.

(B) A review of bathing schedules revealed that residents were not consistently receiving two baths per week, especially baths scheduled for Saturdays or Sundays (see findings under regulation 33(1)) when staff were regularly working short.
Shower staff called in on Sunday July 20, 2014 and was not replaced. Six residents who were on the Sunday schedule did not receive their baths. One was made up on Monday July 21, 2014 as confirmed by the Monday bath staff. The remainder were not made up.
A resident missed three Sunday baths in a row on April 13, 20 and 27th, 2014 when staff worked short.

(C) The home's staffing plan includes a form called the "Working Short Huddle". The written direction to the charge nurse is to complete the form at the beginning of each shift where there is a staff shortage and to submit it to nursing office assistant/scheduler. The form contains a blank box where the charge nurse is expected to document how the front line staff are directed to modify their care routines to address resident care needs for the specific short shift. A random review of seven of these submitted forms revealed that the adjustment of care routines provided no direction to front line staff or were left blank.
The scheduler confirmed that the forms were not being completed as expected. [s. 31. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
(A) Interviews with direct care staff (PSW#6 and #7) revealed that residents are not always getting bathed, especially if the bath person calls in sick. Staff verified that if a bath is refused, an R is marked on the flow sheet. A blank flow sheet would mean the bath was not done. Flow charts for residents scheduled for bathing on Friday, Saturday or Sundays were audited for blank spaces:
(i) On Saturday, July 12, 014 when the bath person called in sick and was not replaced, four residents who were scheduled to be bathed were not done and the baths were not made up when checked on July 15, 2014.
(ii) On Sunday, July 13, 2014, when the bath person called in and was not replaced, five residents scheduled to be bathed on Sunday were not bathed and the baths were not made up when checked July 15, 2014.
(iii) Resident #004 has missed two baths in July up to this date, both on Fridays and not made up.
(iv) Resident #028 missed baths three Sundays in a row in April 2014 that were not made up.
(v) On Sunday July 20, 2014 when the bath person called in and was not replaced, six residents were not bathed. Only one resident bath was made up on Monday July 21, 2014. [s. 33. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures; (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth.

(A) A resident stated in July 2014 that the resident did not receive oral care that day and often went two days before oral care was provided. This was confirmed by two caregivers. The plan of care indicated that the resident required the assistance of staff to perform oral care. [s. 34. (1) (a)]

WN #14: 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 the resident had fallen, the resident was assessed and, when required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident had a fall which resulted in a significant change in the resident's condition.
A review of the resident's clinical record indicated that the staff did not conduct a post fall assessment.
An interview with the RAI Coordinator confirmed that the resident did not receive a post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee did not ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A resident's health record indicated there was no clinical continence assessment completed on admission that included the patterns or type of incontinence experienced by the resident. Several months later when the resident's continence needs changed, a continence assessment was not completed that included the patterns or type of incontinence. Interview with the DOC confirmed the home did not ensure that the identified resident received an assessment that included identification of patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee did not ensure that only residents of the long-term care home may be a member of the Residents' Council.
The secretary of the Resident's Council was not a resident of the home. She was a volunteer. This information was confirmed by the Chair of the Resident Council and the staff liaison. [s. 56. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.
The home did not seek the advice of the resident and Family Councils in the development of the survey questions. This information was confirmed by the Chair of the Resident Council, Family Council and the staff liaison for both councils. [s. 85. (3)]

WN #18: 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 the residents' personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

During interviews with three identified residents, the residents indicated that they have had clothing disappear when taken to the laundry. A review of the Missing Clothing and Articles log indicated that there have been several incidents of clothing that have been missing for periods of time. In November, 2013, there were several items of clothing that were missing due to the laundry department not having any labels to label the clothing. In April, 2014, clothing disappeared that was never returned the resident.
It was confirmed by the interim Housekeeping and Laundry Manager and the Administrator that missing laundry has been an issue. In many of these incidents, residents laundry had gone missing due to clothing not being labelled. [s. 89. (1) (a) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply, including the following: Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator.

On observation the supply room contained government stock drug supply items along with other home stock supplies. Interview with the MDS-RAI coordinator confirmed the ESM has a key and accessed this room to deliver home supply items. DOC confirmed the home did not ensure all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that when a resident was taking any drug, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

(A) An identified resident was taking a medication to manage specific behaviours. In July 2014, the clinical record indicated that the resident was difficult to rouse and could not eat breakfast due to the level of sedation. It was documented on a date in July 2014, by registered staff that resident had been sleepy in the mornings. It was documented that the physician would be alerted. The clinical record indicated that there were no further monitoring or documentation related to the resident's level of sedation. Seven days later, the resident's medication was adjusted, however, there was no monitoring or documentation related to the resident's response or the effectiveness until five days after the adjustment when the inspector identified this to the registered staff.
It was confirmed by the registered staff that there was no monitoring or documentation related to the effectiveness of the change in the resident's medication. (508)

(B) Review of clinical records for a resident identified that the resident experienced symptoms and received medication on an as needed basis on 26 occasions in the month of July 2014 for these symptoms. On 14 of these occasions, there was no monitoring and documentation of the resident's response and the effectiveness of the drug. Interview with the DOC confirmed the licensee did not ensure monitoring and documentation of the response and the effectiveness of the medication as required. (511) [s. 134. (a)]

Issued on this 22nd day of August, 2014

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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) :	BARBARA NAYKALYK-HUNT (146), ROBIN MACKIE (511), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_214146_0014
Log No. / Registre no:	H-000831-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 23, 2014
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	CRESCENT PARK LODGE 4 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY TURNER

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_214146_0061, CO #001;

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 residents as specified in the plan, including residents #023 and #015.
The plan is to be submitted to Barb Naykalyk-Hunt by end of business day August 29, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by e-mail to barbara.naykalyk-hunt@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
(A) A resident's plan of care directed staff to have a specific intervention in place. On a date in July 2014, the resident was observed without the intervention in place. Staff confirmed that it should have been in place. (146)
(B) A resident's plan of care directed staff to provide a specific intervention. On a date in July 2014, the intervention was not implemented as confirmed by staff. (146)
(C) A resident's plan of care indicated that a specific intervention was required. On five days of this inspection the intervention was not provided as directed. This information was confirmed by staff. (146)
(D) A resident's plan of care identified the resident as a moderate nutritional risk and directed staff to provide specific intervention to moderate the risk. The intervention was not provided on a date in May 2014. The DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (511)
(E) A resident stated on three different occasions over several months that a specific intervention was not provided by staff. The DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (511) (146)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 29, 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 23rd day of July, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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