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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 7, 2017	2017_658178_0002	002749-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

SUSAN LUI (178), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548)

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): February 21, 22, 23, 24, 27, 28, March 1, 2, 3, 6, 7, 8, 9, 10, 13, 2017.

The following critical incident and complaint inspections were conducted concurrently during this Resident Quality Inspection:
Log #004161-17, a complaint related to improper care
Logs #028693-16, #031656-16, #033410-16, #035162-16, #002398-17, #002541-17,

#004815-17, and #004672-17, related to alleged incidents of staff to resident physical abuse
Log #033364-16 related to an alleged incident of staff to resident verbal abuse and neglect
Log #028839-16 related to an alleged incident of neglect
Logs #028196-16, #031609-16, and #032114-16, related to alleged incidents of resident to resident physical abuse
Logs #027127-16, #001541-17, #001840-17, and #004446-17, related to resident falls resulting in injury
Log #018784-16 related to resident injury with transfer to hospital and a change in health status

During the course of the inspection, the inspector(s) spoke with residents, family members, the Presidents of Resident and Family Councils, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Dietary Aides, Laundry Aides, the Social Worker, Physiotherapist, Physiotherapy Assistant, Activity Programmers, Receptionist, Scheduler/Payroll Officer, Manager of Support Services, Food Services Supervisor, Dietary Manager, Activities Program Coordinator, Associate Director of Care (ADOC), Acting Associate Director of Care (ADOC-A), Director of Care (DOC), Administrator, Medical Director,

During the course of the inspection the inspectors toured the home and observed resident care being provided, medication administration passes, infection prevention and control practices and meal services. The inspectors reviewed resident health care records, a resident's financial account statement, employee training documents, the residents' mobility equipment cleaning schedule, pest control procedures, and the resident and family council general meeting minutes. The inspectors reviewed documentation related to the home's investigations into the above critical incidents, and policies related to the home's skin and wound care, falls prevention, and prevention of abuse programs.

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with section 5 of the Act in that the licensee failed to ensure that the home is a safe and secure environment for its residents as it relates to the home's service elevator that is also used by the residents for floor to floor movement.

To provide some history to this order, in February 2015, Compliance Order #001 was issued during the Resident Quality Inspection (2015_295556_0005) for section 10(1) of the regulation relating to the rear door of the service elevator as it had not been equipped to restrict resident access to areas that are not permitted to be accessed by residents. This order was issued because the rear door of the service elevator lacked a mechanism to render the door inaccessible to residents and, thus, the rear door could be opened by residents thereby giving them access to the east side service corridor on the first floor. The home had identified the east side service corridor as an area not permitted to be accessed by residents. The home's response to the order was to close and secure the rear door of the service elevator and make it inaccessible to any person, residents included. The order was placed back into compliance on January 15, 2016, during a Follow Up inspection (2016_200148_0003).

During a tour of the home for this Resident Quality Inspection on February 21, 2017, it was noted by Inspector #138 that the rear door of the service elevator was no longer secured closed. The Inspector entered the service elevator from the second floor resident area and accessed the rear door of the service elevator by simply pressing the "IR" button. The service elevator then returned to the first floor and the rear door of the service elevator opened thereby appearing to allow access to the east side service corridor. The Inspector further followed up on February 27, 2017 at 0745 hours, and was able to access the rear door of the service elevator by again pressing the "IR" button once inside the elevator. The Inspector was able to enter the east service corridor once the rear door of the service elevator opened. From there, the Inspector was able to enter the staff kitchen/lunch room and observed access to a water dispensing machine with a hot water feature, no call bell (as used by the home for its resident-staff communication and response system), and several windows at ground level that opened fully to about three feet. It was noted that there was no staff in the area at the time. The Inspector continued to an area across from the staff kitchen/lunch room that appeared to be a receiving area as it had a set of inner double doors and a second set of double doors that led to the outside. The Inspector was able to push through both sets of doors and exit to the parking lot at the back of the building. Neither set of doors were alarmed nor locked. There was no staff present in this area, inside or outside, at the time. The Inspector had a staff assist in locking the double doors prior to leaving the area.

The Inspector met with the Manager of Support Services on February 28, 2017, to discuss the observations made by the Inspector related to the rear door of the service elevator. The Manager of Support Services stated that the home had the elevators refurbished in 2016 including the rear door access control panel of the service elevator

which now provides the home with a mechanism to restrict the use of the rear door through the use of a key. According to the Manager of Support Services, the rear door should only open when staff use a key and unlock the rear door through the rear door access panel. He further stated that staff must re-engage the lock for the rear door of the service elevator once they are finished and must never leave the elevator unattended when the rear door is unlocked.

The Manager of Support Services and the Inspector then proceeded to the service elevator. It was observed by both that the rear door of the service elevator could in fact be opened by simply pressing the "IR" button. No key was required to unlock the rear door. The Manager of Support Services stated that this was not how the rear door should work and would rectify the situation immediately. He came back to the Inspector shortly after and indicated that the rear door of the service elevator had been unlocked but that he had ensured the rear door of the elevator was now locked and that all appropriate staff had a key for the rear door. It is unknown how long the rear door of the service elevator was unlocked giving residents access to the east service corridor.

All residents in the home have access to use the service elevator. Thus, if the rear door to the service elevator is accessible to residents then there is widespread potential risk as residents would have access to the east service corridor. [s. 5.]

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On February 21, 2017, during the home's initial tour, Inspector #573 and #138 observed that the coffee/hot water dispenser machines kept in the second, third, fourth and fifth floor dining room serveries were turned on and were easily accessible to residents without supervision. The Inspectors noted that the water which poured from the dispensers was hot and steaming.

On February 27, 2017, in the second floor dining room Inspector #573 observed residents wandering in the dining room near the servery. The coffee/hot water dispenser machine in the servery was not kept locked and was easily accessible to the residents.

On February 27, 2017, Inspector #573 spoke with the Dietary Manager (DM), who indicated that the coffee/hot water dispensers on all the floors were accessible to residents. The DM stated that the hot beverage dispensers did not have a safety mechanism in place to prevent unsupervised resident access. The DM agreed with the

inspector that residents could potentially burn themselves on the coffee/hot water dispenser machine when the dining room was not supervised. Further the DM recognized that the easy resident access to the coffee/hot water dispenser machine in the dining room serveries could pose a safety risk to the residents with impaired cognitive abilities. [s. 5.]

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 the home is a safe and secure environment for its residents, specifically related to hot beverage dispensers in the dining room serveries, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 15.(1)(a) of the regulation in that the licensee failed to ensure that when bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from

the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as “useful resources” and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings” (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident’s right to participate in the care planning process, the resident’s medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On February 23, 2017, Inspector #138 observed that resident #014’s bed had two rotating assist bed rails which are half rails that were placed in the centre on either side of the bed.

The Inspector spoke to resident #014 several times throughout the inspection and the resident stated to the Inspector that the current bed rails were a part of the bed when the

resident was admitted to the room. The resident stated that the bed rails are used for self repositioning in bed but the resident also stated that the bed rails feel like restraints because when the bed rails are in position they limit the resident's ability to get into and out of bed. The resident further stated that the resident falls frequently and is not supposed to self transfer from the bed to wheelchair or wheelchair to bed but still does as the resident forgets to call for staff assistance. The resident stated that it is difficult to maneuver around the bed rail when it is in place.

The Inspector reviewed resident #014's plan of care (as defined by the home) and noted that the only indication of the use of bed rails for the resident was indicated on the Kardex. The Kardex contained a checked box with the statement: "Bedrails used for bed mobility or transfer". The Inspector then reviewed the health care record and was unable to locate any assessment related to the use of bed rails for resident #014.

The Inspector then spoke with an unidentified PSW regarding the bed rails used for resident #014. The PSW stated that the resident uses the bed rails to assist with bed mobility. The Inspector later spoke with RPN #104 on February 28, 2017, and the RPN stated something different in that the resident uses that specific style of bed rails for falls prevention because the resident is at high risk for falls. The Inspector identified the discrepancies in the reported reasons for the use of the bed rails for resident #014 and so asked RPN #104 about the assessment process for residents using bed rails. RPN #104 stated that the home only conducts such an assessment when full bed rails are used. The RPN stated that there would not be an assessment for resident #014 since the bed rails are partial bed rails and not full bed rails. The RPN further stated that the resident would have those specific bed rails as they were most likely on the bed when the resident was admitted to that room. The RPN further stated that the home is moving towards standardized beds and has removed all beds with full bed rails, replacing with beds that have quarter rails at the head of the bed.

The Inspector proceeded to speak with the Director of Care, the Assistant Director of Care, and the Acting Assistant Director of Care later that same day regarding the assessment process for residents using bed rails. All three confirmed that there was no formal assessment process for residents using bed rails. During this conversation, it was determined that the home recently purchased twenty three new beds all which had quarter bed rails at the head of the bed and that these beds replaced a variety of beds in the home with different styles of bed rails. The Director of Care confirmed that other than the entrapment audit, no formal assessment was completed for those residents receiving the new style of bed with quarter rails at the head of the bed.

The Inspector followed up with the Manger of Support Services as he was responsible for ordering the new beds with quarter rails at the head of the bed. The Manager of Support Services stated that the entrapment audits conducted on beds over the years had identified several beds that were flagged for replacement. The Manger of Support Services stated that all recent beds in the home passed the entrapment audit but the home had replaced twenty three beds in December 2016 in an effort to standardize the bed system in the home. The Manager of Support Services stated that beds replaced in the home were a variety of beds with bed rails and were all replaced with a bed that had two quarter rails in the head of the bed. He further stated that the nursing department provided him with the direction of which specific twenty three beds to replace.

In subsequent discussions, the Director of Care stated that there was no formal assessment for those residents who received one of the twenty three new beds with the quarter rails at the head of the bed. The Director of Care also confirmed that there was no formal assessment for residents admitted to the home into a bed with bed rails nor is there an assessment when a resident's bed with bed rails is changed for other reasons. The Director of Care also stated that she was not familiar with the Health Canada Guidance Document or the companion document that provides guidance for the clinical assessment of residents when bed rails are used.

Every bed in the home has some type of bed rails thus the non compliance described above is widespread and presents the potential for actual harm to residents. [s. 15. (1) (a)]

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #045 as specified in the plan.

An identified Critical Incident Report indicated that on an identified date in January 2017, resident #045 was found on the floor and bleeding profusely from an identified laceration. Further, the CIS report indicated that resident #045 was sent to the hospital for further assessment and was diagnosed with laceration to an identified area.

A second identified Critical Incident Report for resident #045 indicated that on an identified date in February 2017, the resident was found on the floor with a skin tear to an identified area, and injury to an identified joint. Further, the CIS report indicated that resident #045 was sent to the hospital for further assessment.

Inspector #573 reviewed resident #045's health care record, which identified that the resident was at high risk for falls related to the resident's unawareness towards safety needs and unsteady gait. A review of resident #045's progress notes and post fall assessments indicated that resident #045 had a history of multiple falls before and after the fall incident in January 2017. A review of resident #045's post fall assessment in November 2016, root cause analysis for the fall identified resident's poor balance and incontinence. Further, three post fall assessments conducted in January and February 2017, identified the use of a safety bed alarm as one of the recommendations in the follow up plan.

On March 2, 2017, Inspector #573 reviewed resident #045's current written plan of care for falls that included resident close monitoring for every 30 minutes, the use of fall mat and safety bed alarm as fall prevention interventions. Further, the written plan of care for incontinence identified that PSW staff to toilet resident as per the toileting program (every two hours, before and after meals) and as needed.

On March 1 and 2, 2017, Inspector #573 observed resident #045 lying in the bed without any safety bed alarm or fall mat placed near to the resident's bed.

On March 2, 2017, Inspector #573 spoke with resident #045's primary PSW #138, who indicated that resident #045 was at high risk of falls. PSW #138 observed resident #045 in the presence of the inspector and indicated that the safety bed alarm and fall mat was not used for resident #045. PSW #138 indicated to the inspector that in the past, resident

#045 had refused to use a safety bed alarm. PSW #138 also indicated that she was not aware of the fall mat that was used for the resident. Further, the PSW #138 indicated that resident #045 was not on any specific toileting program.

On March 2, 2017, Inspector #573 spoke with RPN #102, who indicated that resident #045's falls were highly related to episodes of some confusion, toileting needs and impaired gait.

During an interview on March 2, 2017, RN #137 indicated to Inspector #573 that resident #045's current fall prevention interventions included resident close monitoring, the use of fall mat and bed safety alarm when the resident is in the bed. Further, she indicated that PSW staff are to toilet the resident as per the toileting program.

Resident #045's care set out in the plan of care regarding falls and continence needs was not provided to the resident as specified in the plan.
(Log #001541-17 and Log #004446-17) [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in resident #045's plan of care is provided to the resident as specified in the plan, 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 their policy: Pressure Ulcers, #03-07, dated: June 2010, is complied with in regards to resident #002's weekly wound assessments.

As per O. Reg. 79/10. S. 50 (2) (b) (iv), the licensee is to ensure that when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is to be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. The licensee's policy Pressure Ulcers, #03-07, dated: June 2010, specifies that the Skin Care Coordinator or delegate will assess and document the assessment of all pressure wounds that are greater than stage 2.

In February 2016 the resident #002 was identified as a moderate risk for pressure ulcers.

The Minimum Data Set assessment reference date in January 2017, indicated that the resident is presenting with a stage 4 pressure ulcer in an identified location.

A clinical assessment tool dated in February 2016, describes the wound and specifies that the pressure ulcer in the identified location is unstageable measuring 0.5 cm x 0.5 cm, obscured by necrosis, the edges are distinct and clearly visible, the necrotic tissue is firmly adherent, hard, black eschar and, the surrounding area is pink in colour.

On February 28, 2017, during an interview with the inspector #548, RPN #122 and on March 1, 2017 RPN #130 both indicated that weekly wound assessments are to be conducted for resident #002 specific to the resident's wounds. RPN #130 indicated that the home's clinical assessment related to skin and wound for resident #002 requires the completion of the Weekly Wound Assessment tool for the assessment, monitoring and

related interventions specific to the resident's identified ulcer.

The Treatment Administration Record (TAR) dated February 2017, specified the need for weekly wound assessments and the required treatment for the identified ulcer. It specifies that this intervention is to be conducted every week on an identified day. It is recorded in the TAR that the registered nursing staff completed the weekly wound assessments, however staff did not document the assessment as required by the home's policy.

On March 1, 2017 RPN #130 reviewed the health care record in the presence of inspector #548 and confirmed that the last documented wound assessment of resident's #002's identified ulcer was conducted two weeks prior. [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 the policy: Pressure Ulcers, #03-07, is complied with in regards to resident #002's weekly wound assessments, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #048.

An identified Critical Incident Report (CIR) indicated that on an identified day in August 2016, resident #048 fell and sustained a hematoma with bleeding to an identified area. Further, the CIR indicated that the fall incident occurred while PSW #145 transferred and repositioned resident #048 in the wheelchair by using a sit to stand mechanical lift.

On March 3, 2017, Inspector #573 reviewed resident #048's written plan of care for transfers at the time of incident which indicated "Total Assistance, sit to stand lift with two staff".

A review of the home's policy entitled Mechanical Lifts – indicated "Two trained staff are required at all times when performing a Mechanical Lift".

On March 03, 2017, Inspector #573 spoke with the Home's ADOC, who indicated that on August 27, 2016, PSW #145 transferred and repositioned resident #048 by using a sit to stand mechanical lift without assistance of another staff member. Further she indicated that PSW #145 failed to follow safe positioning and transferring techniques according to the home's policy while using a sit to stand mechanical lift for resident #048.
(Log #027127-16) [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques when assisting resident #048, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The health care record for resident #019 was reviewed for skin and wound management.

Review of the progress notes from January to February 2017, indicated that on a day in January, 2017, the resident was concerned with regards to a wound in an identified location. A dressing was applied to the wound. The following day, the dressing was removed and treatment given. On an identified day in February 2017, the wound reopened and the area was treated. Approximately one week later, the progress note indicated that a dry dressing was applied to the area.

A progress note entry on an identified date in February 2017, indicated that the resident #019 approached a registered nursing staff member to say that the resident had scratched the area of the above noted wound. The area was described to measure 6cm x 5cm with multiple small scratch areas that were bleeding. The resident had indicated to the staff member that the area was itchy. Treatment was applied.

On March 1, 2017 RPN/RAI coordinator #129 indicated that when there is any alteration in skin such as: rashes, breakdown in skin, abrasions that is first observed, the registered nursing staff are to complete an initial skin assessment on the home's clinically specific assessment tool titled: Weekly Impaired Skin Integrity Assessment. This was concurred with RPN #130 on the unit.

On March 1, 2017 inspector #548 observed the identified area of altered skin integrity for resident #019 to have several crisscrossed dark reddish brown scratch marks.

Upon review of the health care record with the RAI coordinator, there is no completed skin assessment at the onset of the wound in January 2017. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure drugs are secure and locked.

On February 22, 2017 Inspector #573 observed in resident's #025's room on the bedside table two containers of a prescribed cream.

On March 1, 2017 Inspector #548 observed resident #047 enter resident's #025 room. Inspector #548 heard RPN #115 call out to the resident #047 to not to go into the room and she removed the resident from the vicinity. She remarked to the inspector #548 that resident #047 wanders around the unit.

On March 1, 2017 Inspector #548 observed in resident's #025 room on the bedside table one container of prescribed cream.

On further interview the RPN#115 indicated that she is aware the prescribed cream is at the resident #025's bedside as the resident has requested that it be there. She indicated that she is aware that all drugs are to be secure and the drug was removed at the time the inspector was there.

The Inspector #548 reviewed the health record, there was no order for the prescription drug to remain at the resident's #025 bedside. [s. 129. (1) (a)]

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 prescription medications are secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 27.(1)a. of the regulation in that the licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission.

Resident #015 was admitted to the home on an identified date in April 2016, and according to the resident's Power of Attorney (POA), the resident has not had a care conference in the ten months that the resident has been in the home.

Inspector #138 reviewed resident #015's health care record, both electronic and hard copy, and the Inspector was not able to find any indication that a care conference was held for the resident within six weeks of admission. The Inspector spoke with the unit RPN, RPN #104, and she was not able to confirm that a care conference within six weeks of admission had occurred. The Inspector further spoke with the Scheduler/Payroll Officer who had been identified as the person coordinating the care conferences at that time. The Scheduler/Payroll Officer stated to the Inspector that Resident #015 had been scheduled for a care conference in May 2016 but that it had been cancelled as the resident had been out on an identified leave at that time. The Inspector noted from the chart that the resident was on an identified leave at the end of May 2016. The Scheduler/Payroll Officer was not able to provide any documentation to show that the care conference had been rescheduled and held for the resident upon return from the identified leave. [s. 27. (1)]

2. The licensee failed to ensure that a care conference of the interdisciplinary team is

held at least annually.

On February 23, 2017 during a family interview with inspector #548, the Power of Attorney for Care indicated that he/she could not recall if there had been an annual care conference for resident #004 for some time.

The resident was admitted to the home in 2011.

Review of the health care record indicated that the last recorded interdisciplinary care conference for the resident #004 is dated in August 2015. This was confirmed by the Scheduler/Payroll Officer on February 27, 2017.

On February 27, 2017 in the presence of the Inspector #548, the Scheduler/Payroll Officer reviewed the care conference lists for 2016 and 2017. This review indicated there was no care conference held in 2016 for resident #004, and further, that the resident was not listed to be scheduled for a care conference in 2017. The Scheduler/Payroll Officer could not explain the discrepancy.

The home's process to schedule care conferences has been disrupted due to staffing changes since October 2016 as indicated by the Scheduler/Payroll Officer and Assistant Director of Care (ADOC) on February 27, 2017. The ADOC indicated that the home is currently aware of the situation and is working to remedy the issue. [s. 27. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's substitute decision-maker (SDM), if any, were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

On an identified date in February 2017, a Critical Incident Report (CIR) was submitted to the Director related to staff to resident #051 alleged physical abuse. On March 13, 2017, Inspector #573 spoke with the home's DOC, who indicated that she conducted an immediate investigation and the investigation could not verify that abuse had occurred. The DOC indicated to the inspector that the investigation was completed on March 03, 2017 and she had not notified resident #051's SDM with the results of the abuse investigation.
(Log #004815-17) [s. 97. (2)]

Issued on this 7th day of April, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2017_658178_0002
Log No. / Registre no:	002749-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 7, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAURIER MANOR 1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

To EXTENDICARE (CANADA) INC., 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee is ordered to:
1. Ensure that the rear door access panel is used to restrict residents from using the rear door of the service elevator thus ensuring that residents do not have access to the east service corridor without supervision, and
2. Develop and implement an auditing system within 7 days of the order being served that demonstrates whether or not the rear door to the service elevator is accessible to residents. The licensee will document the audit results and have the audit results available for the Follow Up inspection for the Inspector's review.

Grounds / Motifs :

1. The licensee failed to comply with section 5 of the Act in that the licensee failed to ensure that the home is a safe and secure environment for its residents as it relates to the home's service elevator that is also used by the residents for floor to floor movement.

To provide some history to this order, in February 2015, Compliance Order #001 was issued during the Resident Quality Inspection (2015_295556_0005) for section 10(1) of the regulation relating to the rear door of the service elevator as it had not been equipped to restrict resident access to areas that are not permitted to be accessed by residents. This order was issued because the rear door of the service elevator lacked a mechanism to render the door inaccessible to residents and, thus, the rear door could be opened by residents thereby giving them access to the east side service corridor on the first floor. The home had identified the east side service corridor as an area not permitted to be accessed by residents. The home's response to the order was to close and secure the rear door of the service elevator and make it inaccessible to any person, residents included. The order was placed back into compliance on January 15,

2016, during a Follow Up inspection (2016_200148_0003).

During a tour of the home for this Resident Quality Inspection on February 21, 2017, it was noted by Inspector #138 that the rear door of the service elevator was no longer secured closed. The Inspector entered the service elevator from the second floor resident area and accessed the rear door of the service elevator by simply pressing the "IR" button. The service elevator then returned to the first floor and the rear door of the service elevator opened thereby appearing to allow access to the east side service corridor. The Inspector further followed up on February 27, 2017 at 0745 hours, and was able to access the rear door of the service elevator by again pressing the "IR" button once inside the elevator. The Inspector was able to enter the east service corridor once the rear door of the service elevator opened. From there, the Inspector was able to enter the staff kitchen/lunch room and observed access to a water dispensing machine with a hot water feature, no call bell (as used by the home for its resident-staff communication and response system), and several windows at ground level that opened fully to about three feet. It was noted that there was no staff in the area at the time. The Inspector continued to an area across from the staff kitchen/lunch room that appeared to be a receiving area as it had a set of inner double doors and a second set of double doors that led to the outside. The Inspector was able to push through both sets of doors and exit to the parking lot at the back of the building. Neither set of doors were alarmed nor locked. There was no staff present in this area, inside or outside, at the time. The Inspector had a staff assist in locking the double doors prior to leaving the area.

The Inspector met with the Manager of Support Services on February 28, 2017, to discuss the observations made by the Inspector related to the rear door of the service elevator. The Manager of Support Services stated that the home had the elevators refurbished in 2016 including the rear door access control panel of the service elevator which now provides the home with a mechanism to restrict the use of the rear door through the use of a key. According to the Manager of Support Services, the rear door should only open when staff use a key and unlock the rear door through the rear door access panel. He further stated that staff must re-engage the lock for the rear door of the service elevator once they are finished and must never leave the elevator unattended when the rear door is unlocked.

The Manager of Support Services and the Inspector then proceeded to the

service elevator. It was observed by both that the rear door of the service elevator could in fact be opened by simply pressing the "IR" button. No key was required to unlock the rear door. The Manager of Support Services stated that this was not how the rear door should work and would rectify the situation immediately. He came back to the Inspector shortly after and indicated that the rear door of the service elevator had been unlocked but that he had ensured the rear door of the elevator was now locked and that all appropriate staff had a key for the rear door. It is unknown how long the rear door of the service elevator was unlocked giving residents access to the east service corridor.

All residents in the home have access to use the service elevator. Thus, if the rear door to the service elevator is accessible to residents then there is widespread potential risk as residents would have access to the east service corridor.
(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 08, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee is ordered to:
1.Establish and implement a process that enables each resident in the home that uses bed rails to be assessed for the use of these bed rails in accordance with prevailing practices;
2.Ensure that the interdisciplinary team assess all residents in the home who use any type of bed rails, including quarter rails at the head of the bed, and to ensure that all residents hereafter are assessed before the decision to change the style of bed rails used for that resident; and
3.Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment, and the recommendations.

Grounds / Motifs :

1. The licensee failed to comply with section 15.(1)(a) of the regulation in that the licensee failed to ensure that when bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance

Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as “useful resources” and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings” (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident’s right to participate in the care planning process, the resident’s medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On February 23, 2017, Inspector #138 observed that resident #014’s bed had two rotating assist bed rails which are half rails that were placed in the centre on either side of the bed.

The Inspector spoke to resident #014 several times throughout the inspection

and the resident stated to the Inspector that the current bed rails were a part of the bed when the resident was admitted to the room. The resident stated that the bed rails are used for self repositioning in bed but the resident also stated that the bed rails feel like restraints because when the bed rails are in position they limit the resident's ability to get into and out of bed. The resident further stated that the resident falls frequently and is not supposed to self transfer from the bed to wheelchair or wheelchair to bed but still does as the resident forgets to call for staff assistance. The resident stated that it is difficult to maneuver around the bed rail when it is in place.

The Inspector reviewed resident #014's plan of care (as defined by the home) and noted that the only indication of the use of bed rails for the resident was indicated on the Kardex. The Kardex contained a checked box with the statement: "Bedrails used for bed mobility or transfer". The Inspector then reviewed the health care record and was unable to locate any assessment related to the use of bed rails for resident #014.

The Inspector then spoke with an unidentified PSW regarding the bed rails used for resident #014. The PSW stated that the resident uses the bed rails to assist with bed mobility. The Inspector later spoke with RPN #104 on February 28, 2017, and the RPN stated something different in that the resident uses that specific style of bed rails for falls prevention because the resident is at high risk for falls. The Inspector identified the discrepancies in the reported reasons for the use of the bed rails for resident #014 and so asked RPN #104 about the assessment process for residents using bed rails. RPN #104 stated that the home only conducts such an assessment when full bed rails are used. The RPN stated that there would not be an assessment for resident #014 since the bed rails are partial bed rails and not full bed rails. The RPN further stated that the resident would have those specific bed rails as they were most likely on the bed when the resident was admitted to that room. The RPN further stated that the home is moving towards standardized beds and has removed all beds with full bed rails, replacing with beds that have quarter rails at the head of the bed.

The Inspector proceeded to speak with the Director of Care, the Assistant Director of Care, and the Acting Assistant Director of Care later that same day regarding the assessment process for residents using bed rails. All three confirmed that there was no formal assessment process for residents using bed rails. During this conversation, it was determined that the home recently purchased twenty three new beds all which had quarter bed rails at the head of

the bed and that these beds replaced a variety of beds in the home with different styles of bed rails. The Director of Care confirmed that, other than the entrapment audit, no formal assessment was completed for those residents receiving the new style of bed with quarter rails at the head of the bed.

The Inspector followed up with the Manger of Support Services as he was responsible for ordering the new beds with quarter rails at the head of the bed. The Manager of Support Services stated that the entrapment audits conducted on beds over the years had identified several beds that were flagged for replacement. The Manger of Support Services stated that all recent beds in the home passed the entrapment audit but the home had replaced twenty three beds in December 2016 in an effort to standardize the bed system in the home. The Manager of Support Services stated that beds replaced in the home were a variety of beds with bed rails and were all replaced with a bed that had two quarter rails in the head of the bed. He further stated that the nursing department provided him with the direction of which specific twenty three beds to replace.

In subsequent discussions, the Director of Care stated that there was no formal assessment for those resident who received one of the twenty three new bed with the quarter rails at the head of the bed. The Director of Care also confirmed that there was no formal assessment for residents admitted to the home into a bed with bed rails nor is there an assessment when a resident's bed with bed rails is changed for other reasons. The Director of Care also stated that she was not familiar with the Health Canada Guidance Document or the companion document that provides guidance for the clinical assessment of residents when bed rails are used.

Every bed in the home has some type of bed rails thus the non compliance described above is widespread and presents the potential for actual harm to residents.

(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 07, 2017

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

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
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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 7th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

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