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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 27, 2015;	2015_283544_0006 (A1)	S-000504-14, 000490-14, 000468-14, 000740-15	Complaint

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 YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

FRANCA MCMILLAN (544) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the original compliance date of June 8, 2015 to June 30, 2015 for Compliance Order # 001.

Issued on this 27 day of May 2015 (A1)

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

Original report signed by the inspector.

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

FRANCA MCMILLAN (544) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 20, 21, 22, 23, 2015 related to:

Log # S- 000740-15

Log # S- 000504-14

Log # S- 000490-14

Log # S- 000468-14

During the course of the inspection, the inspector(s) spoke with Senior Administrator, Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Staff, Personal Support Workers (PSWs), Staff Scheduler, Residents and Families.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Medication

Personal Support Services

Responsive Behaviours

Sufficient Staffing

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

3 WN(s)
2 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. 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. (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).

Findings/Faits saillants :

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

Inspector # 544 reviewed a Critical Incident Report as a result of a complaint letter that was received by the home. The letter identified multiple concerns regarding the care of Resident # 001.

Inspector # 544 interviewed resident # 001's POA.

A) The resident's POA indicated, during the interview, that resident # 001 had been taken for a shower by a new PSW and PSW students. They indicated that this was not resident # 001's regular scheduled shower day and resident # 001 was agitated, distressed, felt humiliated and could not express their right to refuse. They also indicated resident # 001 was upset that evening and the following day. The POA stated that a fall had occurred that same night and the POA was not notified until the following day, despite the request that they be notified immediately following any incident. They also identified a bruise on resident # 001's back at that time.

The resident's health care record confirmed that the resident's shower days were scheduled on Mondays and Fridays and that the resident was agitated and did not go for dinner that evening. Resident # 001 had a shower on an unscheduled day that upset them. The progress notes indicated that the resident had a fall that same evening and remained agitated for several days after this incident.

Inspector # 544 reviewed resident # 001's care plan and all the progress notes for a three month period and identified that an initial care plan was completed in 2013 and revised in 2015 in regards to the bathing focus. In both care plans it is written, "Resident # 001 prefers a shower. Refer to bath list. Ensure shower days are on their scheduled days, changes causes distress." The regular shower days were not identified in the care plan and resident # 001 had a shower that occurred on one of their non-scheduled days. This was confirmed by S # 200, 201, 206 and the POA.

B) The POA also indicated to the inspector that resident # 001 was visually impaired and some staff PSWs were not aware of this and the communication among staff was "poor." Their visual problems were not addressed in the plan of care other than the focus stated, "partial blindness" and resident # 001 was to wear their glasses. S # 200 and S # 201 confirmed that resident # 001's vision was impaired, was declining and did not have peripheral vision and had very limited vision. PSW staff were to report suspected visual changes to registered staff. It was further written, "Staff assist resident with cleaning their glasses in am and as required. To wear glasses in the morning and remove before bed." The focus that was in the care plan under vision was revised in 2013 and stated, "Resident will maintain their independence with their glasses."
There was no further revision in resident # 001's care plan in regards to resident # 001's vision care or declining vision since 2013. This was confirmed by S # 200 and Staff # 201.

C) Inspector # 544 reviewed resident # 001's health care record and care plans and identified that resident # 001 had 5 falls within a 5 week period.

Inspector # 544 reviewed resident # 001's progress notes for one month in 2015 which indicated that resident # 001 was exhibiting more wandering behaviours and becoming more agitated. This was a significant change in their behaviour.

Resident # 001 had a Morse Fall Risk Assessment completed that identified Resident # 001 as being at a "moderate risk" for falls. Another Morse Fall Risk Assessment was not completed. Resident # 001 had 5 falls following this Morse Fall Risk Assessment.

Inspector reviewed the home's Fall Prevention and Management Program which indicated to "review the resident's fall risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must be addressed then risk factors identified through the assessment process." It further

stated that "ongoing, complete a Morse Fall risk assessment at the time of significant change in resident's status.".

Inspector reviewed the Post Fall Assessment Policy # RESI- 01-02-02 Version April 2013, which indicated to: "Revise and update the resident's care plan to identify the risk level for falls as well as any interventions to prevent re-occurrence. Communicate the changes in the care plan to all staff immediately following the update. Evaluate the strategies implemented in the resident's care plan to determine the effectiveness and make changes as needed."

The care plan, that was completed in 2013, listed the following as interventions:
"Ensure resident uses their walker to ambulate on and off the unit.
Left rail in assist position, right rail in up position."

No further changes were made to the interventions in the care plan until 2015, despite the resident having had two falls before the care plan was changed in 2015. The only other intervention that was added in 2015 was: “risk alert slipper socks" to be applied at HS and remove every morning."

D) Inspector #612 reviewed a Critical Incident Report submitted to the home.

The report indicated physical abuse towards resident # 006 by S # 115.

Resident # 006 was being taken back to their room as the resident was exhibiting responsive behaviours. S # 111 witnessed the abuse and stated that S # 115 grabbed the resident's wrists and held them down while shaking the resident from side to side. Resident # 006 continued to exhibit these responsive behaviours. S # 115 then continued to be physically forceful towards resident # 006. At this point, S # 111 intervened. The nurse in charge was then notified.

Inspector # 612 reviewed residents # 006’s health care record and medication administration record (MAR) and identified that resident # 006 was receiving medication daily, as required, as an effective means of assisting with managing their responsive behaviours. Inspector # 612 reviewed resident # 006's care plan and the focus, goals and interventions listed for their responsive behaviours. The use of this psychotropic medication was not listed. Inspector interviewed S # 106 who confirmed that psychotropic medication was used as an intervention for behaviours however, it was not listed in resident # 006’s care plan and should have been.

E) Inspector # 612 reviewed a Critical Incident Report. Resident # 005 had a fall and sustained a fracture.

Inspector # 612 reviewed resident # 005's health care record and care plan. In the care plan, under the fall focus, the resident was identified as a "high risk" as per Morse Fall Risk Assessment that was completed in 2014. When the inspector reviewed resident # 005's most recent Morse Fall Risk Assessment completed in 2015, resident # 005 was scored as a "moderate risk" for falls.
Inspector # 612 reviewed the care plan with S # 103 who confirmed that the care plan did not match the most recent fall risk assessment.

Inspector # 612 again reviewed resident # 005's care plan. Under the walk in room/corridor focus, the intervention was to encourage resident # 005 to use a walker. Under transfer focus, the intervention was to encourage resident # 005 to use the walker. Under the locomotion on/off unit focus, the intervention was to encourage resident # 005 to use a walker. Throughout the course of the inspection, inspector observed resident # 005, on multiple occasions, ambulating without a walker. Inspector # 612 did not observe a walker in resident #005's room. Inspector interviewed S # 100, S # 103, S # 104, S # 106, S # 107, and S # 112 who confirmed that resident # 005 does not use a walker to ambulate. [s.6. (1) (c)].

2. The licensee has failed to ensure that the resident and the SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

The home had a previous order for failing to ensure that the resident and the SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care under Inspection # 2013_138151_0008 issued on May 31, 2013 and complied on January 17, 2014.

Inspector # 544 reviewed a Critical Incident Report that was submitted as a result of a complaint letter that was received by the home in 2015. The letter identified multiple concerns regarding the care of resident # 001.

Inspector # 544 interviewed resident # 001's POA.

A) Resident # 001 was admitted to the home and there had been several care issues from this time until resident # 001 went to the hospital in 2015. Resident # 001 expired

in the hospital.
The POA told the inspector that they were not given the opportunity to participate fully in the development and implementation of the resident's plan of care and that the family's calls for help were not heard.

The POA told the inspector, that in the first month, resident # 001 developed an eye problem and it was not treated until the POA brought it forward to the Senior Administration of the home, who then was able to get medication for resident # 001's eye problem.

According to the POA, a care plan conference was to be scheduled in late 2014 to resolve some issues and it did not take place. The Head Nurse was unaware of the care conference and another person did not show up. The POA stated that they had numerous care issues to discuss regarding resident # 001.
This care plan conference, that was to be held in late 2014, according to the POA, with resident # 001's POA and family, was not re-scheduled. This was confirmed by S # 200, S # 201 and S # 206.

The POA alleged that the hands on staff did not know resident # 001 nor their care needs. When the POA asked questions of the staff regarding resident # 001, they could not answer their questions and/or the care needs were not communicated from shift to shift or from staff to staff.
The POA felt that their notes were not properly communicated or taken seriously in order for resident # 001's care needs to be communicated properly. There was also a language barrier as resident # 001 spoke very little English.

The only interdisciplinary care conference was held early in 2014 and was to be annual thereafter. The resident expired before the next annual care conference was due.

B) Inspector # 544 reviewed a Complaint submitted to the home in 2014.

The complainant alleged that resident # 003 was ordered a medication that they were not on before and this was not discussed with the resident or the POA by the nurse or the doctor. The POA removed resident # 003 from the home after 24 hours due to concerns about the administration of drugs that the resident was not on at home, without any discussion or input from the resident or POA. Resident # 003 was given a sleeping pill and a drug deemed "as requested" was automatically given to them.

Inspector interviewed S # 200 and S # 204 and both confirmed that when there is a new admission, short stay, respite or long term, that the following process is used:
1. Medication list sent from CCAC Section Q of RAI/MDS
2. The package is sent to the Long Term- Care home when resident is to be admitted.
3. The CCAC medication list on the patient profile report is then transcribed onto the Medical Pharmacies Best Possible Medication Reconciliation form and this is sent to the Pharmacy who fills in the prescriptions to be dispensed.

Section Q of the RAI/MDS assessment that was completed by Community Care Access Centre (CCAC),was missing and was not part of the package sent to the home for reconciliation of medications on admission. Therefore, the medication summary was not correctly reconciled.

Inspector # 544 reviewed resident # 003's health care records, progress notes and doctor's orders. The attending physician's order identified that a sedative was to be taken every 6 hours for a specific condition, which was new for resident # 003, as well as a sleeping tablet at bedtime daily.

The Patient Profile Report from their Community Pharmacy indicated that Resident # 003 was taking a sedative every 6 hours as required, prior to admission, (prn not daily). The attending physician for the home ordered a sedative daily. The Community Pharmacy medication list did not include a sleeping tablet on the list.

There was no documentation found to confirm, identify or support that resident #003's POA was consulted and/or spoke to the physician or nurse after these medications were ordered at the time of resident # 003's admission. The POA was very upset regarding this as the medications were new and asked why they would be ordered this since the resident was not on them at home. It was only after 24 hours that S # 204 reviewed the medications with the POA and the medications had already been given. The POA took the resident home within 1 hour following receipt of the information. S # 204 confirmed that these medications were given prior to being discussed with the POA.
This was also confirmed by S # 206.

Inspector # 544 reviewed the Medical Pharmacies' Patient Counseling - Special Policies Section 10 Policy 10-7 of the Pharmacy Policy and Procedure Manual for LTC Homes.

The policy stated: "Residents and/or their POA/SDM will be informed and educated

about all new medication orders or changes in medication dose."
Procedure: " The resident and/or POA/SDM will be counseled about any new medication orders or changes in medication dose by the nurse. The physician and pharmacist may provide educational counseling as needed upon request. This is then documented by the nurse."

Resident/POA wanted the medication to be given only if requested by resident # 003. Resident # 003 was cognitive but was told by the nurse that it was ordered and they "had to take it as ordered." The resident did so and the next morning, their spouse found them over sedated, could hardly speak and walk. The POA indicated, to the inspector, that they had difficulty getting resident # 003 into the car to take them home.

Resident # 003 told the POA that they felt they were not allowed to exercise their right to refuse or consent to medications that they did not take on a regular basis.

Resident # 003's POA told the inspector that resident # 003 was given a sleeping pill in the evening and a sedative in the morning. This was confirmed by S # 204 who stated that they gave the medication administration record to resident # 003's POA when they took the resident home. [s. 6 (5)].

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized program for personal support services for the home to meet the assessed needs of the residents.

Inspector # 544 reviewed a Complaint sent to the Ministry by a resident's POA in regards to insufficient staffing in the home.

Inspector # 544 interviewed resident # 002's POA via telephone. The POA told the inspector that their family member is a resident in the home and the staffing shortage is still an issue as it pertains to "Personal Support Worker numbers in the home." The complaint was submitted in late 2014 and the POA stated that the problem of insufficient staff to take care of the residents is ongoing today.
According to the POA, the staff work short all the time and they do the best they can. They hurry and at times can't take the appropriate time that a resident's care requires or meet their other needs as planned.

Inspector # 544 reviewed resident # 002's health care record and resident's plan of care and identified that resident # 002 required extensive assistance with all their care needs and their activities of daily living.

Other families and resident told inspector, during the inspection, that they feel residents are not getting the appropriate care and they feel rushed. Some said there is no time for staff to talk to the residents or interact with them when there are staff shortages.

The home's staffing pattern was provided to the inspector by S # 205.
S # 205 also told inspector that an outside staffing agency has now been used to assist in ensuring that the home has a full compliment of staff whenever possible. This agency deploys Registered Staff and Personal Support Workers to different long-term care homes, especially whenever the home's own staff are not able to work when

there are shortages.

S # 206 told the inspector that the staffing plan is based on the care needs of the residents. S # 206 confirmed that there are 224 staff personnel working in the home. Inspector # 544 reviewed the staffing plan and identified the following is the deployment of direct care staff for all resident care areas:
Days
Second Floor- 1 RN, 2 RPNs, 6 PSWs
Third Floor- 1 RN, 2 RPNs, 6 PSWs
Fourth Floor- 1 RN, 2 RPNs, 6 PSWs
Fifth Floor- 1 RN, 2 RPNs, 7 PSWs
Sixth Floor- 1 RN, 2 RPNs, 5 PSWs

Evenings
3 RNs for the building
Second Floor- 2 RPNs and 6 PSWs
Third Floor- 2 RPNs and 6 PSWs
Fourth Floor- 2 RPNs and 6 PSWs
Fifth Floor- 2 RPNs and 6 PSWs
Sixth Floor- 2 RPNs and 5 PSWs

Nights
1 RN for the building
Second Floor- 1 RPN, 2 PSWs
Third Floor- 1 RPN, 1 PSW
Fourth Floor- 1 RPN, 2 PSWs
Fifth Floor- 1 RPN, 2 PSWs
Sixth Floor- 1 RPN, 1 PSW

Inspector # 544 reviewed the staffing compliment for all shifts for four months in the year 2014 and one month in the year 2015 and identified that the planned staffing, for Personal Support Workers, was frequently not met.

The home has a back-up plan when staff shortages occur. S # 204 and S # 206 told inspector that the home at times experiences 1 PSW short on resident care areas and this means that Plan B goes into effect whereby, the personal support staff working need to care for 3-4 extra residents aside from their regular resident care assignment. It was confirmed by S # 206, S # 205 and S # 202 that Plan B means that all resident care areas were not fully staffed on those days and staff that were on duty worked

short. In fact, Plan B meant that there is 1 personal support worker short in some of the resident care areas to provide care to residents. This was confirmed by S # 202, S # 205 and S # 206.

The following are the days that the home did not a have a full deployment of staff on all resident care areas and had one or more Personal Support Workers (PSWs) off duty:
In January 2015, 22/31 days, Plan B was in effect on various shifts on various resident care areas.
In December 2014, 24/31 days, Plan B was in effect on various shifts on various resident care areas.
In November 2014, 27/31 days, Plan B was in effect on various shifts on various resident care areas.
In October 2014, 26/31 days, Plan B was in effect on various shifts on various resident care areas.

Inspector # 544 interviewed S # 202 and Staff # 203
Both staff members stated that the home does work short staff many days throughout the months, in all resident care areas. S # 202 and S # 203 told inspector that some residents exhibit escalating responsive behaviours . They see this as they are called to provide support services to residents in all care areas. They also told the inspector that they are asked to assist with feeding residents and this ultimately hurts the residents who have to wait a long time for care and services. As a result of staff shortages, staff are often unable to take their proper breaks in order to provide care to the residents therefore, some feel very tired and frustrated.

Inspector # 612 interviewed S # 218, from a resident care area, who told the inspector that nail care may need to be provided on the resident's next bath/shower day when Plan B is in effect. S # 218 also told inspector that call bells are answered in priority and some residents may have longer wait times if the call is not a priority.

Inspector # 612 interviewed S # 219, from a resident care area, who told the inspector that they are down to only 4 PSWs, and Plan B is often in effect.
Staff # 219 said that there is a delay in answering call bells. Showers/baths may be missed and moved to the next day and nail care is often not done.

Inspector # 544 interviewed staff on another resident care area.
S # 207, # 208, # 209, # 210, # 211 and # 212 told the inspector that when Plan B is in effect, it means that the two PSWs left on the east and west wings need to do the

work of three, since they are short staff by one PSW. According to the staff, nail care can't be done and is postponed until another time. Staff try to complete the baths on the bath lists but some may need to get moved to the next day or some residents will receive a bed bath when a shower is in their care plan. Call bells are not answered in a timely fashion. It takes longer to answer the call bells and residents have longer wait times.

Inspector # 544 interviewed staff on another resident care area and S # 213, #214, and S # 215 told inspector that nail care is not always provided, staff need to "hustle" and can't spend as much time with residents. Staff told the inspector that they try to do all the baths/showers but offer a bed bath as a last resort. Call bells are answered in priority and some may have longer wait times.

S # 215 also told inspector that residents automatically know when the home is in Plan B staffing pattern as they do not see three familiar faces and only see two PSWs down the east and west resident care areas.

Inspector interviewed Staff # 205 who told inspector that many times they are unable to find staff to replace sick calls and then Plan B goes into effect which means staff who are working need to care for 3-4 other residents not previously assigned to them.

Inspector # 544 interviewed Staff # 207 who confirmed that at times, all staff who call in sick, cannot be replaced and the Plan B goes into effect.

Inspector # 544 interviewed S # 205 who confirmed that the home is presently interviewing candidates for new staff to be hired. Presently the home is intending to hire, 1 full time Registered Nurse, 3 Registered Practical Nurses (RPNs) and 10-12 Personal Support Workers in order to ensure a full compliment of staff for the home.

During the course of the inspection, the inspector observed staff on different resident care areas rushing, busy providing care to the residents and observed that Plan B was in effect on two of the resident care areas.

The home has displayed a pattern of insufficient staffing in regards to Personal Support Workers as determined by the above findings. [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 there was an organized program for personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system is complied with.

The home was issued a Voluntary Plan of Correction (VPC) in regards to any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with under Inspection # 2013_138151_0008 in regards to medication.

2. Inspector # 544 reviewed a Critical incident report as a result of a complaint letter sent to the home in 2015. The letter identified multiple concerns regarding the care of resident # 001.

In the complaint letter, one of the concerns was that resident # 001 had a fall in early 2015 and that the POA was not notified.
The POA went to visit resident # 001 and they were agitated, distressed, complained of back pain and generalized pain in other areas of their body. The POA told the

inspector that they examined resident # 001's back and identified a bruise. Resident # 001 told them that resident # 001 had fallen the night before and was on the floor for a long time. It was not until night shift staff came to work that resident # 001 was found on the floor.
The POA approached the nurse and asked. "What happened?" Only then were they notified of the fall. The POA stated that staff had been instructed to call them at any time of the day and night if there were issues concerning resident # 001. This was written in resident # 001's care plan.

It was written in the "Day Book" for registered staff to call the POA in the morning and this was not done. This was confirmed by S # 200 and S # 201.

S # 200 confirmed that the POA should have been notified immediately or the next morning as per the home's practices and resident # 001's care plan. S # 200 was on duty the next morning and failed to do so.

2. Inspector # 544 reviewed the home's Falls Prevention and Management Program

Version dated April 2013- Resident Care Quality Indicators
Policy Reference # RESI- 10-02-01

It is written, Notify SDM/POA, if applicable. The POA stated that staff had been instructed to call them at any time of the day and night if there was issues concerning resident # 001 and staff did call on other occasions. This was identified in resident # 001's care plan. The POA told the inspector that they were not notified of this specific fall.

Inspector reviewed the Registered Nurse's "Day Book" and it is written "that staff will inform POA on Day shift the next day". This notification was in the day book for the nurse to call the POA however, it was not identified as being done. This is usually done by highlighting the entry and/or a check mark is placed next to it to identify that the task was completed.

There was no documentation in resident # 001's progress notes or health care record to confirm that the POA/SDM was notified of this fall. S # 200 and Staff # 201 told the inspector that resident # 001's POA was not notified regarding this specific fall and it was not checked off in the "Day Book" as a result.

Resident # 001 had five (5) falls after the Morse Fall Risk assessment was completed

in early 2015 and the resident was identified as "moderate risk for falls."

The home's Falls Prevention and Management Program also stated, "Ongoing, complete a Morse Fall assessment for a resident when: A). a fall RAP or CAP is newly triggered in the MDS assessment and B). at the time of significant change in residents status. . Review the residents fall risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process.

Inspector # 544 reviewed Resident # 001's health care record and identified that there was no documentation in Resident # 001's health care record that identified another Morse Fall Risk assessment or re-assessment was completed for Resident # 001. This was confirmed S # 200 and S # 206.

Resident # 001 did not have another Morse Fall assessment completed and an "individualized care plan and communicate the care plan to all staff" as per the home's policy was not completed. Interventions did not address the risk factors identified through the assessment process as per the home's policy.
This was confirmed by S # 200 and S # 201.

3. Inspector # 544 reviewed a Complaint that was submitted by the a resident's POA.

The complaint alleged that resident # 003 was ordered medication that they were not on before and this was not discussed with the resident or the POA at the time of admission. The main issue was the administration of medication without any discussion with doctor, nurse or the POA. Resident # 003 was given a sleeping pill with no conversation with the resident or POA. Another drug was deemed "as requested", but was given to resident # 003 automatically."

Inspector interviewed S # 200 and S # 204 and both indicated when there is a new admission, short stay, respite or long term, the following process is used:
1. Medication list sent from Community care Access Centre (CCAC), Section Q of RAI/MDS
2. The package is sent to the Long Term- Care home when resident is to be admitted.
3. The CCAC medication list on the patient profile report is then transcribed unto the Medical Pharmacies Best Possible Medication Reconciliation and this is sent to the Pharmacy who fills in the scripts and the medications to be dispensed.

Section Q of the RAI/MDS assessment from CCAC was missing and was not part of

the package sent to the home on resident # 003's admission. Therefore, the medications were not correctly reconciled.

Inspector # 544 reviewed resident # 003's health care records, progress notes and doctor's orders.

The attending physician identified that, a sedative daily and a sleeping pill nightly, were new for resident # 003. Resident # 003 was not on these medications at home.

The Patient Profile Report from the Community Pharmacy indicated that Resident # 003 was taking a sedative, 1 tablet every 6 hours as required. The attending physician for the home ordered the sedative to be given by mouth daily. The Community Pharmacy did not have a sleeping pill tablet on resident # 003's medication profile.

Inspector # 544 reviewed the Medical Pharmacies' Patient Counseling - Special Policies Section 10 Policy 10-7 of the Pharmacy Policy and Procedure Manual for LTC Homes.

The policy stated: "Residents and/or their POA/SDM will be informed and educated about all new medication orders or changes in medication dose."
Procedure: " The resident and/or POA/SDM will be counseled about any new medication orders or changes in medication dose by the nurse. The physician and pharmacist may provide educational counseling as needed upon request. This is then documented by the nurse."

The above findings demonstrates that the home failed to ensure that any policy, protocol, procedure, strategy or system is complied with. [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 is complied with, to be implemented voluntarily.

Issued on this 27 day of May 2015 (A1)

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

Ministère 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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : FRANCA MCMILLAN (544) - (A1)

Inspection No. / No de l'inspection : 2015_283544_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000504-14, 000490-14, 000468-14, 000740-15 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : May 27, 2015;(A1)

Licensee / Titulaire de permis :

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

LTC Home / Foyer de SLD :

EXTENDICARE YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Arlene Lesenke

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

Every licensee of a long-term care home shall ensure that there is a written plan of care for resident # 005, resident # 006 and all other residents that sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

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

Inspector # 544 reviewed a Critical Incident Report as a result of a complaint letter that was received by the home. The letter identified multiple concerns regarding the care of Resident # 001.

Inspector # 544 interviewed resident # 001's POA.

A) The resident's POA indicated, during the interview, that resident # 001 had been taken for a shower by a new PSW and PSW students. They indicated that this was not resident # 001's regular scheduled shower day and resident # 001 was agitated, distressed, felt humiliated and could not express their right to refuse. They also indicated resident # 001 was upset that evening and the following day. The POA stated that a fall had occurred that same night and the POA was not notified until the following day, despite the request that they be notified immediately following any incident. They also identified a bruise on resident # 001's back at that time.

The resident's health care record confirmed that the resident's shower days were scheduled on Mondays and Fridays and that the resident was agitated and did not go for dinner that evening. Resident # 001 had a shower on an unscheduled day that upset them. The progress notes indicated that the resident had a fall that same evening and remained agitated for days after this incident.

Inspector # 544 reviewed resident # 001's care plan and all the progress notes for a three month period and identified that an initial care plan was completed in 2013 and revised in 2015 in regards to the bathing focus. In both care plans it is written, "Resident # 001 prefers a shower. Refer to bath list. Ensure shower days are on their scheduled days, changes causes distress." The regular shower days were not identified in the care plan and resident # 001 had a shower that occurred on one of their non-scheduled days. This was confirmed by S # 200, 201, 206 and the POA.

B) The POA also indicated to the inspector that resident # 001 was visually impaired and some staff PSWs were not aware of this and the communication among staff was "poor." Their visual problems were not addressed in the plan of care other than the focus stated, "partial blindness" and resident # 001 was to wear their glasses. S # 200 and S # 201 confirmed that resident # 001's vision was impaired, was declining and did not have peripheral vision and had very limited vision. PSW staff were to report suspected visual changes to registered staff. It was further written, "Staff assist resident with cleaning their glasses in am and as required. To wear glasses in the morning and remove before bed." The focus that was in the care plan under vision was revised in 2013 and stated, "Resident will maintain their independence with their glasses."
There was no further revision in resident # 001's care plan in regards to resident # 001's vision care or declining vision since 2013. This was confirmed by S # 200 and Staff # 201.

C) Inspector # 544 reviewed resident # 001's health care record and care plans and identified that resident # 001 had 5 falls within a 5 week period.

Inspector # 544 reviewed resident # 001's progress notes for one month in 2015 which indicated that resident # 001 was exhibiting more wandering behaviours and becoming more agitated. This was a significant change in their behaviour.

Resident # 001 had a Morse Fall Risk Assessment completed that identified Resident # 001 as being at a "moderate risk" for falls. Another Morse Fall Risk Assessment was not completed. Resident # 001 had 5 falls following this Morse Fall Risk Assessment.

Inspector reviewed the home's Fall Prevention and Management Program which indicated to "review the resident's fall risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must be addressed then risk factors identified through the assessment process." It further stated that "ongoing, complete a Morse Fall risk assessment at the time of significant change in resident's status.".

Inspector reviewed the Post Fall Assessment Policy # RESI- 01-02-02 Version April 2013, which indicated to: "Revise and update the resident's care plan to identify the risk level for falls as well as any interventions to prevent re-occurrence. Communicate the changes in the care plan to all staff immediately following the update. Evaluate the strategies implemented in the resident's care plan to determine the effectiveness and make changes as needed."

The care plan that was completed in 2013 listed the following as interventions: "Ensure resident uses their walker to ambulate on and off the unit.
Left rail in assist position, right rail in up position."

No further changes were made to the interventions in the care plan until 2015, despite the resident having had two falls before the care plan was changed in 2015. The only other intervention that was added in 2015 was: “risk alert slipper socks" to be applied at HS and remove every morning."

D) Inspector #612 reviewed a Critical Incident Report submitted to the home.

The report indicated physical abuse towards resident # 006 by S # 115.

Resident # 006 was being taken back to their room as the resident was exhibiting responsive behaviours. S # 111 witnessed the abuse and stated that S # 115 grabbed the resident's wrists and held them down while shaking the resident from side to side.
Resident # 006 continued to exhibit these responsive behaviours. S # 115 then continued to be physically forceful towards resident # 006. At this point, S # 111 intervened. The nurse in charge was then notified.

Inspector # 612 reviewed residents # 006's health care record and medication administration record (MAR) and identified that resident # 006 was receiving medication daily, as required, as an effective means of assisting with managing their responsive behaviours. Inspector # 612 reviewed resident # 006's care plan and the focus, goals and interventions listed for their responsive behaviours. The use of this psychotropic medication was not listed. Inspector interviewed S # 106 who confirmed that psychotropic medication was used as an intervention for behaviours however, it was not listed in resident # 006's care plan and should have been.

E) Inspector # 612 reviewed a Critical Incident Report. Resident # 005 had a fall and sustained a fracture.

Inspector # 612 reviewed resident # 005's health care record and care plan. In the care plan, under the fall focus, the resident was identified as a "high risk" as per Morse Fall Risk Assessment that was completed in 2014. When the inspector reviewed resident # 005's most recent Morse Fall Risk Assessment completed in 2015, resident # 005 was scored as a "moderate risk" for falls.
Inspector # 612 reviewed the care plan with S # 103 who confirmed that the care plan did not match the most recent fall risk assessment.

Inspector # 612 again reviewed resident # 005's care plan. Under the walk in room/corridor focus, the intervention was to encourage resident # 005 to use a walker. Under transfer focus, the intervention was to encourage resident # 005 to use the walker. Under the locomotion on/off unit focus, the intervention was to encourage resident # 005 to use a walker. Throughout the course of the inspection, inspector observed resident # 005, on multiple occasions, ambulating without a walker. Inspector # 612 did not observe a walker in resident #005's room. Inspector interviewed S # 100, S # 103, S # 104, S # 106, S # 107, and S # 112 who confirmed that resident # 005 does not use a walker to ambulate. s. 6. (1) (c) (544)

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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

Jun 30, 2015(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

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.

Grounds / Motifs :

1. 2. The licensee has failed to ensure that the resident and the SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

The home had a previous order for failing to ensure that the resident and the SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care under Inspection # 2013_138151_0008 issued on May 31, 2013 and complied on January 17, 2014.

Inspector # 544 reviewed a Critical Incident Report that was submitted as a result of a complaint letter that was received by the home in 2015. The letter identified multiple concerns regarding the care of resident # 001.

Inspector # 544 interviewed resident # 001's POA.

A) Resident # 001 was admitted to the home and there had been several care issues from this time until resident # 001 went to the hospital in 2015. Resident # 001 expired in the hospital.

The POA, in an interview, stated to the inspector, that they were not given the opportunity to participate fully in the development and implementation of the residents' plan of care and the family's calls for help were not heard.

The POA told the inspector, that in the first month, resident # 001 developed an eye problem and it was not treated until the POA brought it forward to the Senior Administration of the home, who then was able to get medication for resident # 001's eye problem.

According to the POA, a care plan conference was to be scheduled in late 2014 to resolve several care issues and it did not take place. The Head Nurse was unaware of the care conference and another person did not show up. The POA stated that they had numerous unresolved care issues to discuss.
According to the POA, this care plan conference, that was to be held in late 2014, with resident # 001's POA and family, was not re-scheduled. This was confirmed by S # 200, S # 201 and S # 206.

The POA alleged that the hands on staff did not know resident # 001 nor their care needs. When the POA asked questions of the staff regarding resident # 001, they could not answer their questions and/or the care needs were not communicated from shift to shift or from staff to staff.
The POA felt that their notes were not properly communicated or taken seriously in order for resident # 001's care needs to be communicated properly. There was also a

language barrier as resident # 001 spoke very little English.

The only interdisciplinary care conference was held in early in 2014 and was to be annual thereafter. The resident expired before the next annual care conference was due.

B) Inspector # 544 reviewed a Complaint submitted to the home in 2014.

The complainant alleged that resident # 003 was ordered a medication that they were not on before and this was not discussed with them or the POA by the nurse or the doctor. The POA removed resident # 003 from the home after 24 hours due to concerns about the administration of drugs that the resident was not on at home, without any discussion or input from the resident or POA. Resident # 003 was given a sleeping pill and a drug deemed "as requested" was automatically given to them.

Inspector interviewed S # 200 and S # 204 and both confirmed that when there is a new admission, short stay, respite or long term, that the following process is used:
1. Medication list sent from CCAC Section Q of RAI/MDS
2. The package is sent to the Long Term- Care home when resident is to be admitted.
3. The CCAC medication list on the patient profile report is then transcribed onto the Medical Pharmacies Best Possible Medication Reconciliation form and this is sent to the Pharmacy who fills in the perscriptions to be dispensed.

Section Q of the RAI/MDS assessment that was completed by Community Care Access Centre (CCAC),was missing and was not part of the package sent to the home for reconciliation of medications on admission. Therefore, the medication summary was not correctly reconciled.

Inspector # 544 reviewed resident # 003's health care records, progress notes and doctor's orders. The attending physician's order identified that a sedative was to be taken every 6 hours for a specific condition, which was new for resident # 003, as well as a sleeping tablet at bedtime daily.

The Patient Profile Report from their Community Pharmacy indicated that Resident # 003 was taking a sedative every 6 hours as required (prn not daily). The attending physician for the home ordered a sedative daily. The Community Pharmacy medication list did not include a sleeping tablet on the list.

There was no documentation found to confirm, identify or support that resident #003's POA was consulted and/or spoke to the physician or nurse after these medications were ordered at the time of resident # 003's admission. The POA was very upset regarding this as the medications were new and asked why they would be ordered since resident # 003 was not on them at home. It was only after 24 hours that S # 204 reviewed the medications with the POA and the medications had already been given. The POA took resident # 003 home within 1 hour following receipt of the information. S # 204 confirmed that these medications were given prior to being discussed with the POA.
This was also confirmed by S # 206.

Inspector # 544 reviewed the Medical Pharmacies' Patient Counseling - Special Policies Section 10 Policy 10-7 of the Pharmacy Policy and Procedure Manual for LTC Homes.

The policy stated: "Residents and/or their POA/SDM will be informed and educated about all new medication orders or changes in medication dose."
Procedure: " The resident and/or POA/SDM will be counseled about any new medication orders or changes in medication dose by the nurse. The physician and pharmacist may provide educational counseling as needed upon request. This is then documented by the nurse."

Resident/POA wanted the medication to be given only if requested by resident # 003. Resident # 003 was cognitive but was told by the nurse that it was ordered and they "had to take it as ordered." The resident did so and the next morning, the POA found them over sedated, could hardly speak and walk. The POA indicated, to the inspector, that they had difficulty getting resident # 003 into the car to take them home.

Resident # 003 told the POA that they felt they were not allowed to exercise their right to refuse or consent to medications that they did not take on a regular basis.

Resident # 003's POA told the inspector that resident # 003 was given a sleeping pill in the evening and a sedative in the morning. This was confirmed by S # 204 who stated that they gave the medication administration record to resident # 003's POA when they took the resident home.
s. 6. (5) (544)

Ontario

Ministry of Health and Long-Term Care

Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Jun 08, 2015

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
Télécopieur : 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 27 day of May 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : FRANCA MCMILLAN

Service Area Office /
Bureau régional de services : Sudbury