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

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

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

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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
Jun 28, 2017;	2017_448155_0001 (A1)	000652-17	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street MARKDALE ON N0C 1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

SHARON PERRY (155) - (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): January 10, 11, 12, 13, 14, 16, 17, 18, 19, 2017.

The following intakes were completed within the complaint inspection:

-Log 031933-16 / M606-000011-16 Critical Incident related to an incident that caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status; and

-Log 032082-16 / M606-000013-16 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Office Manager, Scheduler, County Director of Long Term Care, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspectors also toured the home, reviewed relevant clinical records, policies and procedures, schedules, complaint records, internal investigation notes, meeting minutes; observed the provision of resident care, resident-staff interactions, and observed the general cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Nutrition and Hydration

Pain

Reporting and Complaints

Sufficient Staffing

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

- **14 WN(s)**
- **9 VPC(s)**
- **4 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure residents were protected from neglect by staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident was submitted by the home, related to an incident that resulted in an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The resident returned from hospital.

During interviews with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) they both shared that they had attended to the resident prior to them being sent to the hospital. They shared that the resident was experiencing specific symptoms. During an interview a Registered Nurse (RN) said they suspected an injury. The RN told the inspector that when the resident went to hospital a transfer sheet was sent with them which included updated vitals and information regarding why they were being sent. This would have been based on the assessment done by the RN.

Record review showed an assessment for the resident related to this incident. The assessment was not fully completed.

Interviews conducted with a PSW, RPN and RN did not correlate with the assessment started by the RN for the resident. Transfer information sent to the hospital would have been based on this incomplete and inconsistent assessment.

According to the Emergency Facesheet, specific tests were done while the resident was at the hospital.

Review of the resident's clinical record stated that the resident returned from hospital. The resident had identified injuries and symptoms were noted. Upon return from hospital, a PSW recalled a dramatic change in the resident.

During an interview with an RPN, they recalled having provided care for the resident when they returned from hospital. The RPN said the resident experienced symptoms. When asked if a pain assessment would be completed for the resident related to the specific symptoms and that a pain assessment would be completed for the resident related to the specific symptoms they indicated that a pain assessment would have been done.

The Physiotherapist (PT) reported that they had assessed the resident. The PT recalled that when they went to see the resident they had specific symptoms. The PT documented a progress note in Point Click Care to alert staff of the assessment findings and recommended specific treatment. At the same time, the PT spoke with nursing staff and advised them of their assessment and specific treatment they recommended. A progress note documented later that same day showed that staff had not followed the recommendations made by the PT.

Review of the Physicians Orders for the resident identified that when the resident returned from hospital specific medications were ordered . These specific medications got changed when the resident continued to experience symptoms.

Record review and staff interviews identified that the resident was sent to hospital on an identified date following an incident. Documentation showed that the resident had injuries to identified areas and suspected injuries to other areas. It was unclear what was documented on the transfer record to hospital given that the assessment at the time of the incident was incomplete and inconsistent with other documentation. According to progress notes, the resident returned form hospital with specific symptoms. The resident was prescribed medication. Despite these indicators of symptoms and a significant change in status there was no evidence during a review of the resident's clinical record that a required pain assessment was conducted at any point in time after the resident returned from hospital. Despite an assessment by the Physiotherapist which identified specific concerns and specific treatments these were not followed. The specific treatment was not conducted because the physician and staff thought that it had been done. Had the hospital record been reviewed it would have identified that the resident had an alternate treatment done and not the treatment recommended by the Physiotherapist. Upon review of the resident's clinical record there was no evidence that the resident had a skin assessment completed when they returned from hospital when there were noted areas of altered skin integrity. There was no documentation on the record that the resident's alterations in skin integrity were being reassessed and monitored.

During an interview with the Director of Care (DOC), they acknowledged that the identified assessment for the resident was incomplete and that some of the information was not consistent with other documentation. The DOC indicated that the assessment information would not have been helpful if it was included on the resident's transfer record to hospital. The DOC agreed that had staff reviewed the

hospital notes they would have understood that the resident did not have the specific treatment done. Given the nature of the resident's change in condition a full pain assessment should have been completed. This assessment combined with the completion of a full skin assessment might have helped them better evaluate the resident's injuries. There should also have been evidence that the areas of altered skin integrity were being monitored and reassessed. The DOC stated that it was the home's expectation that staff follow recommendations put forward by the Physiotherapist based on their assessment. They reach out to specialties on a regular bases for their opinions and guidance, so it would be important to follow their direction. The DOC acknowledged that there were gaps in the communication, assessment, and documentation of concerns for the resident.

The licensee failed to protect resident #002 from neglect. [s. 19. (1)]

2. Record review showed that a resident was admitted to the home on an identified date. A review of the Discharge Summary/Transfer Note from the physician at the previous facility indicated that while the resident was at the facility, they had increased symptoms that had been relieved at various times with specific treatment.

A review of the resident's progress notes was done and showed that the resident complained of specific symptoms.

Review of the physician's progress notes for the same period was done and showed that there was no documentation indicating that they were aware that the identified resident was having specific symptoms.

During an interview with an RPN, they shared that the resident had complained of the specific symptoms before.
During an interview, another RPN shared that the resident had complained of the specific symptoms before to them. This RPN also shared that the resident did not have an order for treatment of the specific symptoms and thought they had placed the concern on the physician's board for when the physician did their rounds.
During an interview with an RN, they shared that the resident had complained of the identified symptoms before.
During an interview with another identified RPN, they shared that they had worked on an identified date and there was no RN on the shift so they were in charge. This RPN shared that they did go and assess the resident but shared with inspectors that they did not document the assessment. This RPN shared that they

reported the resident's concerns and the medications administered to the resident to the RN when they came on duty.
During an interview with this RN, they recalled on the identified date, that the resident had expressed concerns to the previous shift and that some medication had been given. The RN said that they went and assessed the resident about an hour after the start of their shift. When asked where this assessment was documented, the RN told the inspector that they must of forgot to document it. The RN also shared that when they went to assess the resident they had met a PSW coming out of the room. The inspectors identified the PSW.

Interview with the identified PSW was conflicting to what the RN advised the inspectors during the interview.

During an interview with the PSW, they shared that they went to see the resident around an identified time. When the PSW went back after approximately one hour, they found the resident unresponsive. The PSW alerted the identified RN to come to the room.

During an interview with the Director of Care (DOC), they shared that the resident's history of the identified symptoms should have been included in the plan of care; that the assessments that the RPN and RN informed the inspectors that they had done of the resident were not documented and the expectation was that they were to be documented; that there was no evidence that the physician was notified that the resident was having the identified symptoms and they should have been notified; and there was not RN on duty on the shift of the identified date to assess the resident.

The licensee failed to protect the resident from neglect.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was pattern (level 2) and there was previous unrelated non-compliance (level 2) issued in the last three years. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provides for a staffing mix that was consistent with the residents' assessed care and safety needs.

An anonymous complaint letter was received by the Ministry of Health and Long Term Care (MOHLTC) regarding staff concerns at Grey Gables nursing home. The letter indicated that the home operated short staffed most of the time which had impacted resident care including assessments, bathing, and calls by residents for assistance. It was reported that many staff were working double shifts in order to minimize the shortages but this was leading to increased stress and medical

leaves.
During an interview with the Director of Care and Administrator, the Administrator shared that the home had been struggling with staffing for Personal Support Workers (PSWs). They had paid a great deal of overtime in the last year because they had staff working double shifts in order to provide coverage. They had hired a number of staff over the last year but many were part time and had another job, so they were not always available when they were called to fill a shift. The home had also created a dual classification for some staff, which allowed them to work in more than one area of the home. Despite all of these strategies, they continued to find themselves short staffed on almost a daily basis where they were looking to fill shifts.

Review of the home's Personal Support Workers staffing schedules for an identified period of time indicated the following:
One identified month - Six day or evening shifts where they were short staffed. Five of the six shifts (83%) were on a weekend.
Second identified month - Four day or evening shifts where they were short staffed. Three of the four shifts (75%) were on a weekend.
Third identified month - Sixteen day or evening shifts where they were short staffed. Six of the sixteen shifts were on a weekend (38%).
Nineteen days of another identified month - Four day or evening shifts where they were short staffed. Two of the four shifts were on a weekend (50%).

a) During an interview with and identified resident, they shared that the home seemed to always be shorted staffed. The resident reported that staff were working as hard as they could but they couldn't seem to keep up. The resident said that often when they called for assistance they had to wait, sometimes for upwards of 20 to 30 minutes. When staff did arrive they would apologize and indicated that they were working short. Many times the resident stated that they did not get two baths a week which was their preference and they looked forward to them.

Review of the resident's plan of care identified that the resident would prefer to have two tub baths each week and they were on the schedule.

Review of the Point of Care (POC) documentation for a 47 day period showed that the resident received 8/13 (62%) of their tub baths.

b) During an interview with an identified resident, they shared that they seemed to

be especially short of staff on weekends. In terms of bathing the resident said that they either missed their tub bath or were given a bed bath in its place when they were short staffed or very busy. The resident stated that they would like to have two tub baths a week.

Review of the resident's plan of care identified that the resident was to have two tub baths a week and were scheduled.

POC documentation for bathing identified that in an identified month the resident was provided with 6/9 (67%) tub baths. In another identified month, it was documented that the resident had 7/9 (78%) tub baths.

c) Another identified resident stated during an interview, it was their preference to have a tub bath twice a week

Review of this resident's plan of care for bathing identified that the resident prefers to have two tub baths a week.

Point of Care documentation related to bathing for the resident showed that for one identified month the resident was provided with 7/9 (78%) tub baths. For another identified month, the resident was provided with 4/8 (50%) tub baths. In another identified month it was documented that the resident had 8/9 (89%) tub baths. For another identified 16 day period it was documented that the resident had 4/5 (80%) tub baths.

d) During an interview with an identified resident, they shared that they needed some help with activities of daily living. The resident said that when they called for assistance they often had to wait a long time. The resident shared that there just seemed to never be enough staff. In terms of bathing, the resident shared that they preferred to have two tub baths a week but this didn't often happen.

Review of the resident's plan of care identified that the resident required assistance with activities of daily living. In terms of bathing, the resident preferred two tub baths a week which were scheduled.

Record review of POC showed that in one identified month it was documented for bathing that the resident had 7/9 tub baths (78%). In another identified month the resident had 5/8 (63%) tub baths.

e) Review of an additional eleven residents across the three home areas whose plans of care indicated that they preferred to have two tub baths a week showed the following:

During an identified month – 10/11 (91%) residents had not received two tub baths a week. Of those ten residents that did not receive two tub baths, the percentage of tub baths given was between 33% and 89%.
During another identified month – 10/11 (91%) residents had not received two tub baths a week. Of those ten resident that had not received two tub baths, the percentage of tub baths given was between 44% and 88 %.
During another identified month – 11/11 (100%) residents did not receive two tub baths a week. Of those ten residents that had not received two tub baths, the percentage of tub baths given was between 44% and 89%.
During another sixteen day period – 9/11 (82%) residents did not receive two tub baths a week. Of those nine residents that had not received two tub baths, the percentage of tub baths given was between 40% and 80%.

f) During interviews with thirteen Personal Support Workers, throughout the inspection they indicated that they often worked short. This happened during the week but was even worse on the weekends. Several of the staff stated that they do their very best to complete resident care but it was impossible for it not to suffer when they were short staffed on a regular basis. The Personal Support Workers (PSWs) spoken with during the inspection said that they were not aware of a specific contingency plan that was to be followed when they were short staffed. Sometimes they stayed beyond their shift in order to provide the cares and in other situations they were not able to complete their charting or take their breaks. The staff shared that they were told by management that if they were unable to complete all of the tub baths they should provide residents with a bed bath or ask the next shift to complete the baths. Staff said the only problem with this was that often they were short several shifts in a row and it may be days before they were fully staffed. In this situation residents missed their tub baths and in some cases they did not have time to even provide a bed bath. Four PSWs also stated that toileting residents might be impacted when they were short staffed. They may not have time to toilet a resident as often as needed or they may have to wait when called to a resident's room. In some situations they would have to ask staff on the next shift to toilet the resident if they did not have the time. The staff reported that the ongoing staff shortages were definitely taking a toll on staff morale, stress levels, and absenteeism. Staff also expressed frustration that they were not receiving assistance from the home's management when they were short staffed.

During an interview with the home's Administrator and Director of Care (DOC), they shared that the home did regular audits with respect to whether residents were being bathed. The audits were based on the Resident Assessment Instrument (RAI) schedule and focused on observations of the residents to ensure they were clean, nails clipped and appeared appropriately groomed. The DOC stated that they did not review the documentation on Point of Care as part of their audit. The DOC indicated that staff were directed that when short staffed they were to advise the registered staff if they were not able to complete the baths, provide a bed bath where possible, and if not to inform the oncoming shift so they could catch up. Both the DOC and Administrator indicated that in order to catch up on a few occasions when they were short over a weekend, they had brought on extra staff the next week to provide the missed baths. When shown the Point of Care documentation for the identified period of time for the identified residents, the DOC acknowledged that it would seem that these residents were not getting their preferred twice weekly baths. The staff member further said that it was the home's expectation that staff provide the residents with their preference and if this was not possible to inform the registered staff. The inspectors also noted that on many of dates where baths were not provided the home was short staffed but there were a number of occasions where their staffing logs indicated that they were fully staffed.

The DOC and Administrator acknowledged that they had been short staffed over the last several months and this may have impacted resident care needs such as bathing and toileting.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was pattern (level 2) and there was unrelated non-compliance issued in the last three years (level 2). [s. 31. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident (CI) was submitted by the home. The CI description stated the resident was transferred to the hospital for investigation and treatment.

Upon return from hospital, the physician ordered a specific medication to manage pain. During an identified period of time, the resident's pain level fluctuated. On identified dates this specific medication to manage pain was increased.

The home's policy entitled Pain and Symptom Management, VII-G-30.10, revised December 2015, indicated that Registered staff would conduct and document a pain assessment electronically in a number of situations which included:
- on initiation of a pain medication or as needed analgesic,
- when there is a change in condition with pain onset,
- with distress related behaviours or facial grimacing,
- when receiving pain medication for greater than 72 hours,
- when a resident reports pain or symptoms of greater than 4/10 for 24-48 hours.

Record review indicated that when the identified resident returned from hospital

and for another nine days, the resident experienced some degree of pain. During this time period notations related to pain were documented in the progress notes.

During an interview with two Personal Support Workers (PSW), they recalled having provided care for the resident when they returned from hospital. The staff indicated that when the resident returned, the resident was in a lot of pain. A PSW said they had reported to registered staff quite often that the resident was in pain.

During an interview with a Registered Practical Nurse (RPN) they recalled having provided care for the resident when they returned from hospital. The staff member indicated that pain was an issue. The RPN also recalled that PSWs had reported that the resident was in pain. When asked what the home's practice was in terms of pain assessments, the RPN reported that when a resident returns from hospital or if there is a change in condition accompanied by pain then a pain assessment on Point Click Care should be conducted. The RPN could not recall if a pain assessment had been completed for the resident.

During an interview with a Registered Nurse (RN), they remembered receiving the resident when they returned from hospital. The RN shared that a pain assessment should be conducted if the resident returned with injuries that would potentially cause pain; for residents put on a new analgesic and with any significant change in condition. In terms of the identified resident, the DOC agreed that a pain assessment should have been conducted upon return from hospital and ongoing when pain was not relieved with the interventions provided.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 52. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Record review showed that on an identified date, a resident was administered a combination of drugs.

A RPN shared that they had worked on the identified date and because there was no RN on shift they reported to another RPN that the resident was having symptoms. The RPN shared that the other RPN did assess the resident. The RPN said that they administered a combination of drugs to the resident and that both RPNs reported to the RN that came on duty at a specified time that the resident had symptoms and medications had been given.

During an interview with the other RPN they shared that they did go and assess the resident bud did not document the assessment. The RPN did shared that they reported to the RN that came on duty at a specified that the resident had symptoms and explained the symptoms to the RN and informed them of the medications given.

During an interview, the RN shared that they recalled the identified date, that the resident was having symptoms and had been given medications. The RN said that they went and assessed the resident at an identified time. When asked where this assessment was documented they said that they must of forgot to document it.

During an interview an identified PSW shared that around an identified time they went to get the resident but the resident was unresponsive. The PSW said they alerted the RN to come to the resident.

Review of the documentation for an identified date and time showed that the RN documented that the resident was found unresponsive.

Record review for the resident was done with the Director of Care. They shared the resident should have been reassessed to determine the resident's response and the effectiveness of the medications given and that these assessments should have been documented.

The licensee failed to ensure that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 134. (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Review of the clinical record for an identified resident showed that the resident was sent to hospital and returned with a significant change of status.

During an interview with the Physiotherapist they shared that they assessed the resident and documented their assessment and recommendations.

Review of the resident's clinical record identified a progress note on an identified date by the Physiotherapist which reported their assessments and recommendations.

Review of the resident's most recent plan of care did not reflect the assessment and recommendations of the Physiotherapist.

During an interview with the Director of Care (DOC), they shared that the Physiotherapist was in the home once a week at which time they would assess any resident that may need assessments as well as residents that they had received a specific referral for. When shown the Physiotherapist's assessment findings and recommendations documented on the identified date, the DOC stated that it was the home's expectation that staff would follow these recommendations as that was the point of asking the Physiotherapist to assess. In addition, the DOC acknowledged that the plan of care for the resident should have been updated to reflect the change in care needs in order that all staff would be made aware.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: 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 instituted or otherwise put in place was complied with.

A Critical incident (CI) was submitted by the home on an identified date, related to a specific incident.

As per O.Reg 79/10, s.230. (4) 1. v. the licensee shall ensure that the emergency plans provide for medical emergencies.

The home's policy titled Medical Emergency states that the policy and procedure was designed to ensure a skilled and timely response to a medical emergency, when a person was experiencing a real or suspected imminent loss of life.

The procedure indicated that upon discovering the emergency, pull the nearest call bell and alert nearby staff by shouting specific instructions, stay with the person, and if no response to the call bell or the call for help, page the specific emergency.

During interviews with a registered practical nurse and a personal support worker they shared that they were not aware of any medical emergency code that could be called for this specific medical emergency.

During an interview with the Director of Care, they shared that a medical emergency was not paged on the identified date.

The licensee failed to ensure that the home's policy titled Medical Emergency was complied with.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #7: 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. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

During this inspection a review of the schedule for an identified 109 day period showed that there was no registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present during the following:
-On an identified date for 8 hours.
-On an identified date for 3.5 hours.
-On an identified date for 8 hours.
-On an identified date for 16 hours.
-On an identified date for 12 hours.
-On an identified date for 8 hours.

During interviews with two registered practical nurses, they shared that there was always a registered nurse scheduled however if the registered nurse called in and the home was not able to replace the shift with another registered nurse, a registered practical nurse would be offered the shift with a registered nurse or Director of Care available by telephone.

The Director of Care shared that there was a registered nurse scheduled at all times however call-ins related to illness or poor weather sometimes resulted in not being able to cover the shift with another registered nurse. The Director of Care agreed that during the above shifts there was no registered nurse who was an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

Record review showed the resident was admitted to the home on an identified date. Record review revealed that prior to admission to the home the resident had symptoms that had been relieved at various times with specific treatment.

A review of the resident's progress notes was done and showed that the resident complained of specific symptoms.

Review of the physician's progress notes for the same period was done and showed that there was no documentation indicating that the resident complained of specific symptoms.

Review of the resident's plan of care/care plan did not include that the resident had a history of these specific symptoms.

During interviews done with three registered staff they all shared that the resident had complained about these specific symptoms.

During and interview with the Director of Care a review of the resident's clinical record was done. The Director of Care indicated that the resident should of had the health conditions included in their plan of care/care plan.

The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including pain and other special needs.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was previous non-compliance issued in a similar area in the last three years (level 3). [s. 26. (3) 10.]

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 plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Record review showed that on an identified date, a progress note written indicated that a resident was experiencing some specific symptoms and medications had been administered.

The next documented assessment in the progress notes for the resident was three hours later when the RN wrote that a PSW called them to see the resident.

During an interview with a RPN, they shared that they had worked on the identified date and because there was no RN on the shift they reported to another RPN that the resident was experiencing specific symptoms.

During an interview with the other RPN they shared that they did go and assess the resident but did not document the assessment. The RPN did share that they reported to the registered nurse that came on duty at a specified time that the resident had symptoms and explained the symptoms to the RN and informed them of the medications given.

During an interview, the RN shared that they recalled the identified date, that the resident was having symptoms and that medications had been administered. The RN said that they went and assessed the resident at an identified time. When asked where this assessment was documented they indicated that they must of forgot to document it.

The Director of Care shared that the resident should have been reassessed and that these assessments should have been documented in the progress notes.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) was submitted by the home on an identified date that indicated that a resident had a fall. The resident was transferred to hospital for further investigation and treatment.

Review of the clinical record for the resident showed that a post-fall risk assessment was initiated on an identified date and revised seven days later. The assessment was not completed in full.

During an interview with the Director of Care, they shared that post-fall, it was the home's expectation that registered staff conduct a post-fall assessment which would be documented in the risk management report. Information from this assessment would then push to the progress notes. The assessment should include a description of the incident, injuries/potential injuries, a physical assessment of the resident including pain, as well as any contributing factors related to the fall. The Director of Care stated that while a post-fall assessment was initiated for the resident's fall, some of the information documented was incorrect and the assessment was not completed.

The licensee failed to ensure that when the identified resident fell, the resident was assessed using a clinically appropriate assessment instrument specifically designed for falls.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance The licensee shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #11: 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, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of an identified resident's clinical record identified that on an identified date the resident had a fall. The resident was transferred to hospital for further investigation and treatment. When the resident returned from the hospital, progress notes indicated that the resident had altered skin integrity. There was no skin assessment found for the resident.

Review of the home's policy entitled Skin and Wound Care Management Protocol, the procedure indicated that registered staff would conduct a full skin assessment for residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds.

During an interview with the Director of Care, they indicated that it was the home's expectation that registered staff complete the skin assessment tool on Point Click Care for resident's exhibiting altered skin integrity. The Director of Care acknowledged that a skin assessment was not conducted for the area of altered skin integrity for the identified resident.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [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 #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

During the course of the inspection two Personal Support Workers shared that they had brought concerns forward to the management of the home regarding specific resident care issues. In both cases the staff indicated that they were not sure if the home had investigated these concerns as they were not provided with a follow-up related to the complaints.

The home's policy entitled "Complaints - Response Guidelines" VI-G-10.00, stated that any complaint (verbal, written, telephone, or e-mail) received at the home or corporate office from residents, families, visitors, and staff shall be investigated and actions shall be taken for resolution. According to the policy, in the case of both verbal and written complaints an investigation would be conducted and documented. The complainant would be contacted and provided with actions taken to resolve the complaint. The final resolution would also be documented.

During an interview with the home's Administrator and Director of Care, they indicated that complaints received from families, residents and visitors were logged on Point Click Care including the date the complaint was received. The investigation findings were also documented with the actions taken to resolve the complaint including dates, time frames, and follow-up. Any response by the complainant was also recorded. When asked if this process was also used for complaints or concerns related to resident care and services brought forward by staff in the home, the Administrator and DOC both indicated that they did not record those types of complaints on the log for privacy reasons. The Administrator and DOC both acknowledged that they had not ensured that a documented record was kept for those concerns / complaints brought to their attention by staff, nor was there a written log of the nature of these complaints, date received, type of actions taken, and response to the complainant.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee failed to test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that would be involved in responding to an emergency.

The home's Medical Emergency policy and procedure indicates that it was designed to ensure a skilled and timely response to a medical emergency.

During an interview with the Director of Care, they shared that the home's Medical Emergency policy and procedure was not tested in the last three years.

The Administrator shared that the home's Medical Emergency policy and procedure was not tested on an annual basis.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 230. (7) (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 the licensee shall test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies partner facilities and resources that will be involved in responding to an emergency, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

On an identified date it was documented that a resident had complained of specific symptoms and medications were administered.

Three hours later, it was documented that a registered nurse was called to see the resident by a personal support worker. The resident was unresponsive.

Review of the physician's progress notes was done.

A review of the resident's record was done with the Director of Care and they shared that a critical incident should have been submitted.

The Administrator shared that a critical incident for the resident had not been submitted.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 107. (1) 2.]

Issued on this 28 day of June 2017 (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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
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130, avenue Dufferin, 4ème étage
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Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHARON PERRY (155) - (A1)

Inspection No. / No de l'inspection : 2017_448155_0001 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000652-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 28, 2017;(A1)

Licensee / Titulaire de permis : CORPORATION OF THE COUNTY OF GREY
206 Toronto Street, MARKDALE, ON, N0C-1H0

LTC Home / Foyer de SLD : GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH, MARKDALE, ON, N0C-1H0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jennifer Cornell

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

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

Order / Ordre :

The licensee shall protect residents from neglect by staff and ensure that changes in a resident's condition including increased pain, skin concerns, including bruises, are communicated, documented by all staff, and that there is a process in place to ensure that the residents are reassessed and interventions are in place to address these concerns.

Grounds / Motifs :

1. The licensee failed to ensure residents were protected from neglect by staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Record review showed that a resident was admitted to the home on an identified date. A review of the Discharge Summary/Transfer Note from the physician at the previous facility indicated that while the resident was at the facility, they had increased symptoms that had been relieved at various times with specific treatment.

A review of the resident's progress notes was done and showed that the resident complained of specific symptoms.

Review of the physician's progress notes for the same period was done and showed that there was no documentation indicating that they were aware that the identified resident was having specific symptoms.

During an interview with an RPN, they shared that the resident had complained of the specific symptoms before.
During an interview, another RPN shared that the resident had complained of the specific symptoms before to them. This RPN also shared that the resident did not have an order for treatment of the specific symptoms and thought they had placed the concern on the physician's board for when the physician did their rounds.
During an interview with an RN, they shared that the resident had complained of the identified symptoms before.
During an interview with another identified RPN, they shared that they had worked on an identified date and there was no RN on the shift so they were in charge. This RPN shared that they did go and assess the resident but shared with inspectors that they did not document the assessment. This RPN shared that they reported the resident's concerns and the medications administered to the resident to the RN when they came on duty.
During an interview with this RN, they recalled on the identified date, that the resident had expressed concerns to the previous shift and that some medication had been given. The RN said that they went and assessed the resident about an hour after the start of their shift. When asked where this assessment was documented, the RN told the inspector that they must of forgot to document it. The RN also shared that when they went to assess the resident they had met a PSW coming out of the room. The inspectors identified the PSW.

Interview with the identified PSW was conflicting to what the RN advised the inspectors during the interview.

During an interview with the PSW, they shared that they went to see the resident around an identified time. When the PSW went back after approximately one hour, they found the resident unresponsive. The PSW alerted the identified RN to come to the room.

During an interview with the Director of Care (DOC), they shared that the resident's history of the identified symptoms should have been included in the plan of care; that the assessments that the RPN and RN informed the inspectors that they had done of

the resident were not documented and the expectation was that they were to be documented; that there was no evidence that the physician was notified that the resident was having the identified symptoms and they should have been notified; and there was not RN on duty on the shift of the identified date to assess the resident.

The licensee failed to protect the resident from neglect.
(155)

2. A Critical Incident was submitted by the home, related to an incident that resulted in an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The resident returned from hospital.

During interviews with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) they both shared that they had attended to the resident prior to them being sent to the hospital. They shared that the resident was experiencing specific symptoms. During an interview a Registered Nurse (RN) said they suspected an injury. The RN told the inspector that when the resident went to hospital a transfer sheet was sent with them which included updated vitals and information regarding why they were being sent. This would have been based on the assessment done by the RN.

Record review showed an assessment for the resident related to this incident. The assessment was not fully completed.

Interviews conducted with a PSW, RPN and RN did not correlate with the assessment started by the RN for the resident. Transfer information sent to the hospital would have been based on this incomplete and inconsistent assessment.

According to the Emergency Facesheet, specific tests were done while the resident was at the hospital.

Review of the resident's clinical record stated that the resident returned from hospital. The resident had identified injuries and symptoms were noted. Upon return from hospital, a PSW recalled a dramatic change in the resident.

During an interview with an RPN, they recalled having provided care for the resident when they returned from hospital. The RPN said the resident experienced symptoms. When asked if a pain assessment would be completed for the resident related to the specific symptoms they indicated that a pain assessment would be completed for the resident related to the specific symptoms and that a pain assessment would have been done.

The Physiotherapist (PT) reported that they had assessed the resident. The PT recalled that when they went to see the resident they had specific symptoms. The PT documented a progress note in Point Click Care to alert staff of the assessment findings and recommended specific treatment. At the same time, the PT spoke with nursing staff and advised them of their assessment and specific treatment they recommended. A progress note documented later that same day showed that staff had not followed the recommendations made by the PT.

Review of the Physicians Orders for the resident identified that when the resident returned from hospital specific medications were ordered . These specific medications got changed when the resident continued to experience symptoms.

Record review and staff interviews identified that the resident was sent to hospital on an identified date following an incident. Documentation indicated that the resident had injuries to identified areas and suspected injuries to other areas. It was unclear what was documented on the transfer record to hospital given that the assessment at the time of the incident was incomplete and inconsistent with other documentation. According to progress notes, the resident returned form hospital with specific symptoms. The resident was prescribed medication. Despite these indicators of symptoms and a significant change in status there was no evidence during a review of the resident's clinical record that a required pain assessment was conducted at any point in time after the resident returned from hospital. Despite an assessment by the Physiotherapist which identified specific concerns and specific treatments these were not followed. The specific treatment was not conducted because the physician and staff thought that it had been done. Had the hospital record been reviewed it would have identified that the resident had an alternate treatment done and not the treatment recommended by the Physiotherapist. Upon review of the resident's clinical record there was no evidence that the resident had a skin assessment completed when they returned from hospital when there were noted areas of altered skin integrity. There was no documentation on the record that the resident's alterations in skin integrity were being reassessed and monitored.

During an interview with the Director of Care (DOC), they acknowledged that the identified assessment for the resident was incomplete and that some of the information was not consistent with other documentation. The DOC indicated that the assessment information would not have been helpful if it was included on the resident's transfer record to hospital. The DOC agreed that had staff reviewed the hospital notes they would have understood that the resident did not have the specific treatment done. Given the nature of the resident's change in condition a full pain assessment should have been completed. This assessment combined with the completion of a full skin assessment might have helped them better evaluate the resident's injuries. There should also have been evidence that the areas of altered skin integrity were being monitored and reassessed. The DOC stated that it was the home's expectation that staff follow recommendations put forward by the Physiotherapist based on their assessment. They reach out to specialties on a regular bases for their opinions and guidance, so it would be important to follow their direction. The DOC acknowledged that there were gaps in the communication, assessment, and documentation of concerns for the resident.

The licensee failed to protect resident #002 from neglect. [s. 19. (1)]

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was pattern (level 2) and there was previous unrelated non-compliance (level 2) issued in the last three years.
(568)

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

Mar 10, 2017

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

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

Order / Ordre :

The licensee must ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and meets the requirements set out in the Act and this Regulation.
The licensee must assess the resident's care and safety needs on each resident living area.
The licensee must review the home's staffing pattern regarding Personal Support Workers hours on each resident living area and ensure that there are enough Personal Support Workers/direct care staff to meet the residents' assessed care and safety needs.

Grounds / Motifs :

1. An anonymous complaint letter was received by the Ministry of Health and Long Term Care (MOHLTC) regarding staff concerns at Grey Gables nursing home. The letter indicated that the home operated short staffed most of the time which had

impacted resident care including assessments, bathing, and calls by residents for assistance. It was reported that many staff were working double shifts in order to minimize the shortages but this was leading to increased stress and medical leaves.

During an interview with the Director of Care and Administrator, the Administrator shared that the home had been struggling with staffing for Personal Support Workers (PSWs). They had paid a great deal of overtime in the last year because they had staff working double shifts in order to provide coverage. They had hired a number of staff over the last year but many were part time and had another job, so they were not always available when they were called to fill a shift. The home had also created a dual classification for some staff, which allowed them to work in more than one area of the home. Despite all of these strategies, they continued to find themselves short staffed on almost a daily basis where they were looking to fill shifts.

Review of the home's Personal Support Workers staffing schedules for an identified period of time indicated the following:
One identified month - Six day or evening shifts where they were short staffed. Five of the six shifts (83%) were on a weekend.
Second identified month - Four day or evening shifts where they were short staffed. Three of the four shifts (75%) were on a weekend.
Third identified month - Sixteen day or evening shifts where they were short staffed. Six of the sixteen shifts were on a weekend (38%).
Nineteen days of another identified month - Four day or evening shifts where they were short staffed. Two of the four shifts were on a weekend (50%).

a) During an interview with and identified resident, they shared that the home seemed to always be shorted staffed. The resident reported that staff were working as hard as they could but they couldn't seem to keep up. The resident said that often when they called for assistance they had to wait, sometimes for upwards of 20 to 30 minutes. When staff did arrive they would apologize and indicated that they were working short. Many times the resident stated that they did not get two baths a week which was their preference and they looked forward to them.

Review of the resident's plan of care identified that the resident would prefer to have two tub baths each week and they were on the schedule.

Review of the Point of Care (POC) documentation for a 47 day period showed that the resident received 8/13 (62%) of their tub baths.

b) During an interview with an identified resident, they shared that they seemed to be especially short of staff on weekends. In terms of bathing the resident said that they either missed their tub bath or were given a bed bath in its place when they were short staffed or very busy. The resident stated that they would like to have two tub baths a week.

Review of the resident's plan of care identified that the resident was to have two tub baths a week and were scheduled.

POC documentation for bathing identified that in an identified month the resident was provided with 6/9 (67%) tub baths. In another identified month, it was documented that the resident had 7/9 (78%) tub baths.

c) Another identified resident stated during an interview, it was their preference to have a tub bath twice a week

Review of this resident's plan of care for bathing identified that the resident prefers to have two tub baths a week.

Point of Care documentation related to bathing for the resident showed that for one identified month the resident was provided with 7/9 (78%) tub baths. For another identified month, the resident was provided with 4/8 (50%) tub baths. In another identified month it was documented that the resident had 8/9 (89%) tub baths. For another identified 16 day period it was documented that the resident had 4/5 (80%) tub baths.

d) During an interview with an identified resident, they shared that they needed some help with activities of daily living. The resident said that when they called for assistance they often had to wait a long time. The resident shared that there just seemed to never be enough staff. In terms of bathing, the resident shared that they preferred to have two tub baths a week but this didn't often happen.

Review of the resident's plan of care identified that the resident required assistance with activities of daily living. In terms of bathing, the resident preferred two tub baths a week which were scheduled.

Record review of POC showed that in one identified month it was documented for

bathing that the resident had 7/9 tub baths (78%). In another identified month the resident had 5/8 (63%) tub baths.

e) Review of an additional eleven residents across the three home areas whose plans of care indicated that they preferred to have two tub baths a week showed the following:

During an identified month – 10/11 (91%) residents had not received two tub baths a week. Of those ten residents that did not receive two tub baths, the percentage of tub baths given was between 33% and 89%.
During another identified month – 10/11 (91%) residents had not received two tub baths a week. Of those ten resident that had not received two tub baths, the percentage of tub baths given was between 44% and 88 %.
During another identified month – 11/11 (100%) residents did not receive two tub baths a week. Of those ten residents that had not received two tub baths, the percentage of tub baths given was between 44% and 89%.
During another sixteen day period – 9/11 (82%) residents did not receive two tub baths a week. Of those nine residents that had not received two tub baths, the percentage of tub baths given was between 40% and 80%.

f) During interviews with thirteen Personal Support Workers, throughout the inspection they indicated that they often worked short. This happened during the week but was even worse on the weekends. Several of the staff stated that they do their very best to complete resident care but it was impossible for it not to suffer when they were short staffed on a regular basis. The Personal Support Workers (PSWs) spoken with during the inspection said that they were not aware of a specific contingency plan that was to be followed when they were short staffed. Sometimes they stayed beyond their shift in order to provide the cares and in other situations they were not able to complete their charting or take their breaks. The staff shared that they were told by management that if they were unable to complete all of the tub baths they should provide residents with a bed bath or ask the next shift to complete the baths. Staff said the only problem with this was that often they were short several shifts in a row and it may be days before they were fully staffed. In this situation residents missed their tub baths and in some cases they did not have time to even provide a bed bath. Four PSWs also stated that toileting residents might be impacted when they were short staffed. They may not have time to toilet a resident as often as needed or they may have to wait when called to a resident's room. In some situations they would have to ask staff on the next shift to toilet the resident if

they did not have the time. The staff reported that the ongoing staff shortages were definitely taking a toll on staff morale, stress levels, and absenteeism. Staff also expressed frustration that they were not receiving assistance from the home's management when they were short staffed.

During an interview with the home's Administrator and Director of Care (DOC), they shared that the home did regular audits with respect to whether residents were being bathed. The audits were based on the Resident Assessment Instrument (RAI) schedule and focused on observations of the residents to ensure they were clean, nails clipped and appeared appropriately groomed. The DOC stated that they did not review the documentation on Point of Care as part of their audit. The DOC indicated that staff were directed that when short staffed they were to advise the registered staff if they were not able to complete the baths, provide a bed bath where possible, and if not to inform the oncoming shift so they could catch up. Both the DOC and Administrator indicated that in order to catch up on a few occasions when they were short over a weekend, they had brought on extra staff the next week to provide the missed baths. When shown the Point of Care documentation for the identified period of time for the identified residents, the DOC acknowledged that it would seem that these residents were not getting their preferred twice weekly baths. The staff member further said that it was the home's expectation that staff provide the residents with their preference and if this was not possible to inform the registered staff. The inspectors also noted that on many of dates where baths were not provided the home was short staffed but there were a number of occasions where their staffing logs indicated that they were fully staffed.

The DOC and Administrator acknowledged that they had been short staffed over the last several months and this may have impacted resident care needs such as bathing and toileting.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was pattern (level 2) and there was unrelated non-compliance issued in the last three years (level 2). (568)

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

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

Jun 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. A Critical Incident (CI) was submitted by the home. The CI description stated the resident was transferred to the hospital for investigation and treatment.

Upon return from hospital, the physician ordered a specific medication to manage pain. During an identified period of time, the resident's pain level fluctuated. On identified dates this specific medication to manage pain was increased.

The home's policy entitled Pain and Symptom Management, VII-G-30.10, revised December 2015, indicated that Registered staff would conduct and document a pain assessment electronically in a number of situations which included:
- on initiation of a pain medication or as needed analgesic,

- when there is a change in condition with pain onset,
- with distress related behaviours or facial grimacing,
- when receiving pain medication for greater than 72 hours,
- when a resident reports pain or symptoms of greater than 4/10 for 24-48 hours.

Record review indicated that when the identified resident returned from hospital and for another nine days, the resident experienced some degree of pain. During this time period notations related to pain were documented in the progress notes.

During an interview with two Personal Support Workers (PSW), they recalled having provided care for the resident when they returned from hospital. The staff indicated that when the resident returned, the resident was in a lot of pain. A PSW said they had reported to registered staff quite often that the resident was in pain.

During an interview with a Registered Practical Nurse (RPN) they recalled having provided care for the resident when they returned from hospital. The staff member indicated that pain was an issue. The RPN also recalled that PSWs had reported that the resident was in pain. When asked what the home's practice was in terms of pain assessments, the RPN reported that when a resident returns from hospital or if there is a change in condition accompanied by pain then a pain assessment on Point Click Care should be conducted. The RPN could not recall if a pain assessment had been completed for the resident.

During an interview with a Registered Nurse (RN), they remembered receiving the resident when they returned from hospital. The RN shared that a pain assessment should be conducted if the resident returned with injuries that would potentially cause pain; for residents put on a new analgesic and with any significant change in condition. In terms of the identified resident, the DOC agreed that a pain assessment should have been conducted upon return from hospital and ongoing when pain was not relieved with the interventions provided.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 52. (2)]

CO#004
Record review showed that on an identified date, a resident was administered a combination of drugs.

A RPN shared that they had worked on the identified date and because there was no RN on shift they reported to another RPN that the resident was having symptoms. The RPN shared that the other RPN did assess the resident. The RPN said that they administered a combination of drugs to the resident and that both RPNs reported to the RN that came on duty at a specified time that the resident had symptoms and medications had been given.

During an interview with the other RPN they shared that they did go and assess the resident bud did not document the assessment. The RPN did shared that they reported to the RN that came on duty at a specified that the resident had symptoms and explained the symptoms to the RN and informed them of the medications given.

During an interview, the RN shared that they recalled the identified date, that the resident was having symptoms and had been given medications. The RN said that they went and assessed the resident at an identified time. When asked where this assessment was documented they said that they must of forgot to document it.

During an interview an identified PSW shared that around an identified time they went to get the resident but the resident was unresponsive. The PSW said they alerted the RN to come to the resident.

Review of the documentation for an identified date and time showed that the RN documented that the resident was found unresponsive.

Record review for the resident was done with the Director of Care. They shared the resident should have been reassessed to determine the resident's response and the effectiveness of the medications given and that these assessments should have been documented.

The licensee failed to ensure that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2).
(568)

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 :

Mar 10, 2017

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must ensure that when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Grounds / Motifs :

1. Record review showed that on an identified date, a resident was administered a combination of drugs.

A RPN shared that they had worked on the identified date and because there was no RN on shift they reported to another RPN that the resident was having symptoms. The RPN shared that the other RPN did assess the resident. The RPN said that they administered a combination of drugs to the resident and that both RPNs reported to the RN that came on duty at a specified time that the resident had symptoms and medications had been given.

During an interview with the other RPN they shared that they did go and assess the resident bud did not document the assessment. The RPN did shared that they reported to the RN that came on duty at a specified that the resident had symptoms and explained the symptoms to the RN and informed them of the medications given.

During an interview, the RN shared that they recalled the identified date, that the resident was having symptoms and had been given medications. The RN said that they went and assessed the resident at an identified time. When asked where this assessment was documented they said that they must of forgot to document it.

During an interview an identified PSW shared that around an identified time they went to get the resident but the resident was unresponsive. The PSW said they alerted the RN to come to the resident.

Review of the documentation for an identified date and time showed that the RN documented that the resident was found unresponsive.

Record review for the resident was done with the Director of Care. They shared the resident should have been reassessed to determine the resident's response and the effectiveness of the medications given and that these assessments should have been documented.

The licensee failed to ensure that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

During this inspection this non-compliance was found to have a severity level of actual harm/risk (level 3), the scope was isolated (level 1) and there was unrelated non-complianace issued in the last three years (level 2). (155)

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

Mar 10, 2017

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

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
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
Toronto ON M5S 2B1
Télécopieur : 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
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 28 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY - (A1)

Service Area Office /
Bureau régional de services : London