Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2014	2014_339579_0013	S-000265-14	Resident Quality Inspection

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road, Box 179, Wawa, ON, P0S-1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0

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

JANET MCNABB (579), LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 8, 9, 10, 15, 16 and 17, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Registered Dietitian (RD), the Nutritional Manager, Personal Support Workers (PSWs), Registered Nursing Staff, Dietary Aides, the Infection Control Contact, the Activity Director, Family Members and Residents.

During the course of the inspection, the inspector(s) reviewed resident health records, various policies and procedures, walked through resident home areas, observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector #575 reviewed the restraint record for resident #956 for 2 months in 2014. Based on this documentation there was no indication that the resident had been repositioned every 2 hours when wearing a restraint on 24 days. One morning beginning at approximately the hour of 0830, the inspectors observed resident #956 sitting at the breakfast table with their restraints on and then every 15 minutes approached and observed resident in the same position, over a 2 1/2 hour time period.
Inspector #579 interviewed resident #956 after the observation 2 hour time period and asked how they were. They stated their back was sore and they had to get up. Then staff #105 came and sat with resident and read them a story until 1045h. At that time, inspector #579 asked staff #105 about resident #956's repositioning and staff #105 indicated that they were not sure if the resident had been repositioned in the last 2

hours. The inspector also interviewed the resident about being repositioned in the last 2 hours and they reported they had not been repositioned. Inspector #579 interviewed staff #111 who reported that they had brought the resident to the bathroom before breakfast, which therefore had been two and one half hours ago since the last repositioning. During the course of the inspection inspector #575 reviewed the Least Restraint policy last updated June 24, 2010. The policy states that a member of the nursing or personal care staff shall release, reposition and reapply a physical restraint every hour while a resident is awake or more often according to the needs of the individual.
The licensee failed to ensure that staff released resident #956 from the physical device and repositioned at least every two hours. [s. 110. (2) 4.]

2. Inspector #575 reviewed the restraint records from 2 months in 2014 for residents #950, #954 and #956. The restraint records indicated that nursing initials are required every 8 hours and code either "N" for necessary or "NR" for no longer required. The inspector noted that on 15 separate days nursing initials and/or coding was missing. Inspector #575 reviewed the progress notes during this period and did not find any documentation regarding re-assessment of the resident's condition or effectiveness of the restraint. Inspector #575 interviewed staff #112 who stated that every 8 hours the nursing staff sign off, confirming that the resident was checked every hour while in restraints.
The licensee failed to ensure that resident #950, #954 and #956's conditions were reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any
other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

3. Inspector #575 reviewed the restraint records for 2 months in 2014 for residents #950, #954 and #956. The inspector noted that the restraint records did not indicate who applied the restraint device. The inspector reviewed the progress notes during the same time period and noted there was no indication of who applied the restraint device. Staff #112 confirmed to the inspector that the restraint documentation does not include who applied the device.
The licensee failed to ensure that the documentation included the person who applied the device. [s. 110. (7) 5.]

Additional Required Actions:

CO # - 001, 002 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

Findings/Faits saillants :

1. Inspector #579 reviewed the minutes of the last meeting of the infection control committee, which was April 23rd, 2013. The inspector was unable to locate any meeting minutes after April 23, 2013. The meeting prior to this was held on October 11, 2012 as noted from the minutes of the meeting of April 23, 2013. It was reported to the inspector that these infection control committee meetings were joint meetings with acute care as well as the long-term care sections of the facility. Staff #102 confirmed that they have not had a meeting since April 23, 2013.

The licensee has failed to ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).
(2) The licensee failed to ensure that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly. [s. 229. (2) (b)]

2. Inspector #579 did a record review of the infection prevention and control policies (IPAC) and many were dated between 2006 and 2009, and several of these policies had no review date. The recently appointed infection prevention and control contact, staff #102, is unaware of when the IPAC program, including it's policies and procedures, will be next reviewed.
The licensee has failed to ensure that the program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices; and that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the name of the person who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 229. (2) (d)]

3. Inspector interviewed staff #102 who is in charge of infection control and newly assigned to this role for approximately 1 1/2 years. It was identified by the inspector that the staff member #102 does not have any of the required education and experience in Infection Prevention and Control nor are they registered for any related courses.
The licensee has failed to designate a staff member to coordinate the program who has education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management. [s. 229. (3)]

4. During the course of the inspection, inspector #575 observed staff #104 during medication administration for residents #949, #940, and #939. No hand washing was observed being done by staff #104 before entering these residents' rooms or before administration of their medication. Further, hand washing was not observed on exit of resident #949's room by staff #104.
Also during the course of the inspection, inspectors observed staff #106 cough into their hands and proceed to distribute cutlery in the dining room. No hand washing was observed by this staff after coughing into their hands.

The licensee failed to ensure that staff participates in the implementation of the

infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

CO # - 003, 004 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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #575 reviewed the health care records for residents #950, #954 and #956. The inspector noted that the residents required the use of 2 bed rails when in bed for safety. Inspector #575 interviewed the DOC regarding steps used to prevent entrapment. The DOC confirmed with the inspector that entrapment and zones of entrapment are not/have not been formally tested.
The licensee did not ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all zones of entrapment. [s. 15. (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 bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all zones of entrapment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. During the course of the inspection, inspector #575 observed medication administration by staff #104. The inspector noted the disposal of used Fentanyl patches, removed from residents, into the regular garbage container on two separate occasions. Staff #104 stated that there is no policy regarding the disposal of Fentanyl patches. An interview took place with the DOC, who also confirmed there is no policy for disposal of used Fentanyl patches.
The licensee did not ensure that the home's drug destruction and disposal policy included that drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 136. (2) 3.]

2. Inspector #575 interviewed the DOC regarding drug destruction. The DOC informed the inspector that narcotics or controlled substances are destroyed by an RN (usually staff #107) and a registered practical nurse. It was reported to inspector #575 by the DOC that there was no pharmacist or physician involvement at all for the narcotic destruction. Inspector #575 reviewed the drug destruction records and confirmed the narcotic or controlled drugs are destroyed by these staff, two registered nursing staff.
The licensee did not ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist. [s. 136. (3) (a)]

3. Inspector #575 reviewed the most recent drug destruction records for narcotic or controlled drugs. The inspector noted that the records do not indicate the prescription number of the drug, the reason for destruction, the names of the persons who destroyed the drug, or the manner of destruction of the drug.
The licensee failed to ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1.The date of removal of the drug from the drug storage area
2.The name of the resident for whom the drug was prescribed, where applicable
3.The prescription number of the drug, where applicable
4.The drug's name, strength and quantity
5.The reason for destruction
6.The date when the drug was destroyed
7.The names of the persons who destroyed the drug
8.The manner of destruction of the drug. [s. 136. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are destroyed in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and, that the drugs must be destroyed by a team acting together and composed of, (a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist; and, ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1. The date of removal of the drug from the drug storage area
2. The name of the resident for whom the drug was prescribed, where applicable
3. The prescription number of the drug, where applicable
4. The drug's name, strength and quantity
5. The reason for destruction
6. The date when the drug was destroyed
7. The names of the persons who destroyed the drug
8. The manner of destruction of the drug, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. Inspector #579 reviewed the health care record of resident #944's, specifically their plan of care, related ulcer identified on the plan of care and the interventions listed included a chemical debriding agent to be applied every second day and covered with wound care wrap.
Inspector #579 reviewed the doctor's orders with staff #105 and no order was found for the chemical debriding agent. Most recent orders included a prescription cream, an absorbent factor and then just cleansing for this wound treatments.
Inspector #579 Interviewed staff #105 and they identified that the wound had been healed recently and that the care plan had not been updated.
Care plan in the resident's chart, accessible to the PSWs, was dated as reviewed a date in February, 2014 and care plan in the software program of point click care, not accessible to the PSWs, was updated as of May, 2014.
Inspector interviewed staff #104 regarding resident #944's pressure ulcers. MDS indicated that resident has 3 pressure ulcers. Staff #104 verified that the resident only had one pressure ulcer and has had this wound since 2013.
In section M for resident #944 the RAI the coding was coded 3 ulcers in error.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #575 interviewed resident #950's substitute decision maker (SDM) regarding notification of treatment changes. The resident's SDM stated that they are not notified when there is a change in the resident's treatment. The SDM stated that a few months ago the resident began exhibiting a change in behaviour for approximately one week. The SDM stated that they asked the nursing staff if there were any changes to the resident's medications and the staff informed the SDM that a new medication had been ordered and administered. The SDM then informed the home to stop the medication and the resident's behaviours were resolved. The SDM stated that they are only advised of treatment changes when the SDM asks.
Inspector #575 interviewed staff #104 regarding SDM notification of treatment changes. Staff #104 stated that they might not notify an SDM for all new medications. Staff #104 stated that when SDM's are notified it is documented in the progress notes and further stated that on occasion they might inform an SDM in passing and forget to document.
Inspector #575 reviewed the health care records for resident #950. A new medication was ordered on a date in 2014. On a later date in 2014 the SDM was visiting and asked if there was anything new as they had noticed a difference in the resident's behaviours. The SDM was then informed about the new medication order. The medication was then ordered to be held due to the SDM notifying the home of resident #950's increased behaviours. The medication was then discontinued later on in 2014.
Inspector #575 reviewed the progress notes for 3 months and there was not any documentation regarding SDM notification prior to the discovery at the SDM's visit.
The licensee did not ensure that resident #950's SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. Inspector #575 reviewed resident #949's health care record. The care plan indicated that the resident has a wound and staff is to cleanse the wound with normal saline and apply a padded Tegaderm daily.
Inspector #575 interviewed resident #949 regarding the wound. The resident stated that the staff does not clean the wound daily and told the inspector that they independently clean the wound daily. Inspector #575 observed that the wound was open to air, slightly reddened with dried blood.
Inspector #575 interviewed staff #110 regarding resident #949's wound. Staff #110

stated that the resident has had the wound since admission and it is something that likely will not heal. The staff member stated that the resident is independent and performs the daily cleaning and usually applies a bandage.
Inspector #575 interviewed staff #104 who stated that staff is to clean the wound daily and apply a bandage.
Inspector #575 further reviewed resident #949's care plan and the resident is documented as having a history of chest pain and care plan interventions included vital signs to be taken every Wednesday. Inspector #575 reviewed the vital signs flow sheet for 2014 and identified that the resident had vital signs recorded only on 5/13 days. On July 15, 2014 inspector #575 confirmed with staff #104 that all residents' vital signs are to be taken every Wednesday. The DOC provided inspector #575 with the Admission to Long-Term Care policy last reviewed Sept 16, 2013. The policy indicated that vital signs (temperature, pulse, respirations, and blood pressure) will be taken on admission and weekly.
The licensee failed to ensure that the care set out in the plan of care was provided to resident #949 as specified in the plan. [s. 6. (7)]

4. On July 15, 2014 inspector #575 noted that resident #949's care plan in the resident's chart was dated January 16, 2014 however the most recent care plan in the software program was dated April 17, 2014. The PSWs do not have access to electronic Plans of Care.

The licensee did not ensure that staff and others who provide direct care to a resident, kept aware of the contents of the plan of care and have convenient and immediate access to it. [s. 6. (8)]

5. Inspector #575 reviewed resident #950's care plan in the resident's chart and noted it was dated January 31, 2014 however the most recent care plan review and update in the point click care (PCC) software program was dated April 30, 2014.
Inspector #579 did a record review of resident #952's care plan and the review date is dated last reviewed and updated on February 20th, 2014 and the PCC software updated care plan is dated May 23rd, 2014.
Inspector #579 did a record review of resident #940's care plan in the residents chart, that is available to the direct care staff, and it was dated as reviewed and updated Feb. 10, 2014 and the PCC updated care plan was dated April 15th, 2014.
Staff interviews of PSWs identified that the PSWs do not have access to electronic care plans and access the care plans in the residents' charts. Inspector #579 interviewed staff #104 and staff #107, who stated they were surprised and unaware

that the most current dated care plan was not printed out for the residents charts and therefor not providing immediate access by the direct care staff.
The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the residents' plan of care and have convenient and immediate access to it. s. 6 (8) [s. 6. (8)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Inspectors #579 and #575 interviewed the dietitian (RD) regarding the home's nutrition and hydration programs policies and procedures. Residents #950 and #954 were identified as being at nutritional risk and were receiving supplements. In the current policy and procedure there are nutritional assessment templates and tools to use to apply to these residents for their nutritional care. The RD indicated that they were not aware of any dietary/nutritional policies and/or any forms to be used for assessments. Inspectors showed the RD the forms attached to the policies and the RD was not aware of these forms. The RD indicated that the resident dietary assessment notes were made in the Dietitian's Notes section of the health care record.
The licensee failed to ensure that the nutrition care and hydration programs include the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff. [s. 68. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. Inspector #575 reviewed the health care record for resident #950. The inspector noted that over 2 months in 2014 resident #950 lost 6kg or 12% of the resident's weight. The last dietitian (RD) assessment was completed 2 months before the weight change. The inspector interviewed the RD regarding the process for monitoring weights. The RD told the inspector that there is currently no policy regarding the process for notifying the dietitian about weight changes. The staff member confirmed that weights are reviewed on a quarterly basis and if there is a significant change in weight, the dietitian relies on nursing staff to advise them.
Inspector interviewed staff #107 regarding the process for monitoring weights. Staff #107 stated that it is expected that if there is a decrease of 3 kg, staff should notify them and then the dietitian would be made aware. The inspector further reviewed the plan of care for resident #950 and confirmed that no changes were made to address the significant weight loss.
The licensee failed to ensure that resident #950 with a weight change of 5 per cent of body weight, or more, over one month is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. During the course of the inspection, inspector #575 observed a lunch dining service. The inspector noted that the dessert posted for lunch was lemon pudding however the actual dessert was yogurt parfait. Inspector #575 interviewed staff #106 regarding menu substitutions. Staff #106 stated that substitutions are communicated by the cook the day before and that it would be posted on the menu board. The Nutrition Manager told the inspector that the substitutions are communicated to residents verbally and the menu board is updated by food service staff so that both residents and staff are aware of the menu changes. The Dietitian told the inspector that substitutions are communicated to residents by the menu board that is updated by the nursing staff. Inspector noted that the menu board was not updated with the substitution.
The licensee failed to ensure that all menu substitutions are communicated to residents and staff. [s. 72. (2) (f)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On two separate occasions during the inspection, inspector #575 observed lunch dining service. The inspector noted that the breakfast menu was not posted, desserts for lunch were not posted and the weekly menu was rolled up leaning on a ledge outside the dining area. Inspector interviewed the RD who indicated that breakfast is not normally posted. Inspector #575 noted that the breakfast menu was not posted and the weekly menu remained rolled up outside the dining area, not visible to residents throughout the course of the inspection. The Dietitian and the Nutrition Manager confirmed that the weekly menus are communicated by the menu board.
The licensee failed to ensure that the daily and weekly menus are communicated to residents. [s. 73. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. During the inspection, inspector #575 reviewed the health care records for resident #950, #954 and #956 and observed these residents, confirming the use of restraints. Inspector #575 interviewed the DOC regarding the home's restraints process. The DOC stated that the home does not keep a written record of the monthly analysis, the annual evaluation, the changes and improvements required and the date of the annual evaluation, the names of the persons who participated in the evaluation and the date the changes were implemented.
The licensee failed to ensure that a written record of the following is promptly prepared with regards to the restraining by a physical device:
•The monthly analysis, the annual evaluation and the changes and improvements required;
•the date of the annual evaluation;
•the names of the persons who participated in the evaluation; and
•the date that the changes were implemented, is in place. [s. 113. (e)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. In July, 2014 inspector #575 observed medication administration for resident #949 by staff #104. The staff member was administering an injectable medication to resident #949. A second staff #109 double checked the order, however did not sign their name. Staff #109 stated that they do not co-sign for this injectable medication as there is not an area to initial. In July, 2014 inspector #575 reviewed the homes "High Alert Medications - Identification, Independent Double Check" policy last reviewed May 28, 2009 provided by the DOC. The policy states that an independent double-check is required for specific high alert medications, including this injectable medication. The policy indicates that documentation of the double check will be completed on the medication administration record (MAR) and will include the nurses initials, date, and time.
Additionally, in July, 2014 inspector #575 observed staff #104 sign the medication administration record (MAR) before administering a narcotic to resident's #939 and #940. On July 17, 2014 inspector #575 asked the DOC what the expectation was regarding signing the MAR. The DOC indicated that staff should be signing the MAR after administration of the medication, including narcotics.
The licensee did not ensure that written policies and protocols are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 114. (3) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. In July, 2014 inspector #575 observed the medication cart. The inspector noted that a medication cup was left on top of the unattended medication cart containing white creamy liquid and was labelled with a black marker "Cream name and room number". The inspector confirmed with staff #105 that the substance was a medicated cream for resident #944.
Additionally, the inspector noted an unlabelled prescription ointment the medication cart.
The licensee did not ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In July, 2014 inspector #575 observed a drawn up syringe of a prescription drug in the medication cart labelled for resident #939 from 2 days earlier than the observation. In July, 2014 inspector #575 observed medication administration for resident #949 by staff #104. The inspector noted that this medication was stored in the medication cart and noted no date indicating when this medication was open. Inspector #575 asked staff #104 what the normal process was for labelling the medication. The staff member told the inspector that the staff are to write the date on the vial when it is opened. The inspector reviewed the homes "Dating of multidose packages" policy last revised Dec 2006 that identifies that upon opening a multidose package, the nurse shall write on the package the date on which it was opened.
Additionally, in July, 2014 inspector #575 noted two expired medications in the home's drug storage room: stool softener drops expired 04/14 and cough syrup expired 12/13. The licensee did not ensure that drugs that are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that complies with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

Issued on this 10th day of December, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET MCNABB (579), LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2014_339579_0013
Log No. / Registre no:	S-000265-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 5, 2014
Licensee / Titulaire de permis :	LADY DUNN HEALTH CENTRE 17 Government Road, Box 179, Wawa, ON, P0S-1K0
LTC Home / Foyer de SLD :	LADY DUNN HEALTH CENTRE 17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SALLY GARLAND

To LADY DUNN HEALTH CENTRE, 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 :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure compliance with O. Reg 79/10, s. 110 (2) and that the following requirements are met specifically for residents #950, #954 and #956 that are being restrained by a physical device under section 31 of the Act: That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.); That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Grounds / Motifs :

1. Inspector #575 reviewed the restraint record for resident #956 for 2 months in 2014. Based on this documentation there was no indication that the resident had been repositioned every 2 hours when wearing a restraints on 24 days. One morning beginning at approximately the hour of 0830, the inspectors observed resident #956 sitting at the breakfast table with their restraints on and then every 15 minutes approached and observed resident in the same position, over a 2 1/2 hour time period.
Inspector #579 interviewed resident #956 after the observation 2 hour time period and asked how they were. They stated their back was sore and they had to get up. Then staff #105 came and sat with resident and read them a story until 1045h. At that time, inspector #579 asked staff #105 about resident #956's repositioning and staff #105 indicated that they were not sure if the resident had been repositioned in the last 2 hours. The inspector also interviewed the resident about being repositioned in the last 2 hours and they reported they had not been repositioned. Inspector #579 interviewed staff #111 who reported that they had brought the resident to the bathroom before breakfast, which therefore had been two and one half hours ago since the last repositioning. During the course of the inspection inspector #575 reviewed the Least Restraint policy last updated June 24, 2010. The policy states that a member of the nursing or personal care staff shall release, reposition and reapply a physical restraint every hour while a resident is awake or more often according to the needs of the individual.
The licensee failed to ensure that staff released resident #956 from the physical device and repositioned at least every two hours. [s. 110. (2) 4.] (575)

2. Inspector #575 reviewed the restraint records from 2 months in 2014 for residents #950, #954 and #956. The restraint records indicated that nursing

initials are required every 8 hours and code either "N" for necessary or "NR" for no longer required. The inspector noted that on 15 separate days nursing initials and/or coding was missing. Inspector #575 reviewed the progress notes during this period and did not find any documentation regarding re-assessment of the resident's condition or effectiveness of the restraint. Inspector #575 interviewed staff #112 who stated that every 8 hours the nursing staff sign off, confirming that the resident was checked every hour while in restraints.
The licensee failed to ensure that resident #950, #954 and #956's conditions were reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. [s. 110. (2) 6.] (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall comply with LTCHA, 2007 O. Reg. 79/10, s. 110 (7) to ensure for each resident, specifically related to residents # 950, # 954 and # 956 that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Grounds / Motifs :

1. Inspector #575 reviewed the restraint records for 2 months in 2014 for residents #950, #954 and #956. The inspector noted that the restraint records did not indicate who applied the restraint device. The inspector reviewed the progress notes during the same time period and noted there was no indication of who applied the restraint device. Staff #112 confirmed to the inspector that the restraint documentation does not include who applied the device.
The licensee failed to ensure that the documentation included the person who applied the device. [s. 110. (7) 5.] (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall ensure compliance with O. Reg. 79/10, s. 229 (1) whereby there is an interdisciplinary team that co-ordinates and implements the program and meets at least quarterly, that the infection control program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices; and that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the name of the person who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Grounds / Motifs :

1. Inspector #579 reviewed the minutes of the last meeting of the infection control committee, which was April 23rd, 2013. The inspector was unable to locate any meeting minutes after April 23, 2013. The meeting prior to this was held on October 11, 2012 as noted from the minutes of the meeting of April 23, 2013. It was reported to the inspector that these infection control committee meetings were joint meetings with acute care as well as the long- term care sections of the facility. Staff #102 confirmed that they have not had a meeting since April 23, 2013.
The licensee has failed to ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).
(2) The licensee failed to ensure that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly. (579)

2. Inspector #579 did a record review of the infection prevention and control (IPAC) policies and many were dated between 2006 and 2009, and several of these policies had no review date. The recently appointed infection prevention and control contact staff #102 is unaware of when the IPAC program, including it's policies and procedures, will be next reviewed.
The licensee has failed to ensure that the program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices; and that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the name of the person who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. (579)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Order / Ordre :

The licensee shall ensure compliance with O. Reg. 79/10, s. 229 (3), whereby the current designated staff member who coordinate the Infection Prevention and Control Program obtains education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

Grounds / Motifs :

1. Inspector interviewed staff #102 who is in charge of infection control and newly assigned to this role for approximately 1 1/2 years. It was identified by the inspector that the staff member #102 does not have any of the required education and experience in Infection Prevention and Control nor are they registered for any related courses.
The licensee has failed to designate a staff member to coordinate the program who has education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management. (579)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet McNabb

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