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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2013	2013_191107_0009	H-000498-13, H-000249-13	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

MICHELLE WARRENER (107), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 22, 23, 27, 28, 29, 30, 2013 - Telephone interviews were also conducted off-site on additional dates

This reports relates to inspections H-000549-13, H-000498-13, H-000249-13

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care (DOC), Registered Dietitian (RD), Nutrition Manager (NM), Registered (RN/RPN) and front line nursing staff (PSW), Behavioural Supports Ontario (BSO) staff, external wound care nurse, and former employees of the home

During the course of the inspection, the inspector(s) toured the home, reviewed the clinical health records of identified residents, observed the lunch meal service related to positioning, reviewed relevant policies and procedures, observed toileting and positioning and residents with evidence of skin breakdown

The following Inspection Protocols were used during this inspection:
Dining Observation

Medication

Minimizing of Restraining

Nutrition and Hydration

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued August 30, 2011 as a CO, December 18, 2012 as a CO, January 9, 2013 as a CO
The plan of care for resident #013, related to constipation, did not set out clear directions for the staff and others who provided direct care to the resident. The resident's plan of care did not provide clear direction on what to do when problems occurred. The resident had concerns noted in the progress notes, however, it was not clear if further action was required. During interview staff voiced concerns over the resident and a need for further direction related to constipation.

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of resident #001 related to constipation and skin integrity.
A) The RAI-MDS admission assessment coding, stated the resident was continent of bowel with regular bowel movements every 1-3 days (no constipation). The admission assessment for pain, completed the same day identified constipation. A dietary referral to the Registered Dietitian was also completed the same day for constipation. The assessments were not consistent with each other related to constipation. (107)
B) The Admission Minimum Data Set (MDS) assessment for resident #001 identified the presence of skin breakdown as well as a history of an open area that was resolved or cured in last 90 days. The Resident Assessment Protocol (RAP) completed based on the assessment identified that the resident did not have any current skin breakdown and no previous ulcers. The assessments were not consistent with each other. (168)
C) The MDS assessment for resident #001 identified open areas on the skin, staged at a certain level, related to pressure. The RAP completed for this assessment indicated that the areas were at a different stage than the MDS coding assessment. (168) [s. 6. (4) (a)]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(b)]
Staff did not collaborate with each other in the development and implementation of resident #001's plan of care so that the different aspects of care were integrated, consistent with and complemented each other in relation to the resident's hydration. The resident's plan of care identified a target amount of fluids per day, however, nutritional assessments by the Registered Dietitian identified a fluid target of a different target amount of fluids daily. The plan of care was completed by a different dietitian than the dietitian who completed the nutritional assessment. The resident had

been below their assessed fluid requirement on all but eight days during a three month period, however, the resident's hydration was not flagged as being below their assessed requirement. The two dietitians did not collaborate in the development and implementation of the plan of care related to hydration. Interview with the home's Registered Dietitian confirmed that the resident required the higher level of fluids, however, the other dietitian had entered the home's minimum requirement according to policy, not what the resident's assessed needs reflected. [s. 6. (4) (b)]

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)(c)] Previously issued Aug 30, 2011 as a CO, December 18, 2012 as a CO, January 9, 2013 as a CO
A) Resident #009 was not reassessed and their plan of care revised when the resident's care needs changed and the care set out in the plan was not effective in relation to hydration and constipation.
i) The resident had a 26% significant weight gain over a five month period, however, a re-assessment of the resident's hydration requirements in relation to the weight gain did not occur at the identified nutritional review. The resident was regularly documented as consuming less fluids than the previously assessed fluid requirement, however, an assessment of the resident's intake in relation to identified goals did not occur. The resident consumed less than their identified fluid requirement on numerous days over a four month period (61% of days the first month reviewed, 40% of days the subsequent month, 48% of days the next month, and 64% the next month), and had two periods of less than 12 servings over three consecutive days (the home's policy stated a referral to the dietitian was required for this), without a referral to the dietitian and without a documented assessment of the poor hydration below the identified goals for the resident. The resident's hydration plan of care was not revised in relation the weight gain or continued fluid intake below the established goal for the resident.
ii) Resident #009 was not reassessed and their plan of care reviewed and revised when the care set out in the plan was not effective in relation to constipation.
The resident had a plan of care requiring nutritional interventions daily for the treatment of constipation, however, an evaluation of the effectiveness of the nutrition intervention was not completed, and the resident continued to receive as needed medical treatment for constipation. Constipation was noted at the RAI-MDS Nutritional Status RAP, however, the resident's dietary plan of care was not revised in relation to interventions for the prevention and treatment of constipation.
B) Resident #001 was not reassessed and their plan of care reviewed and revised when the care set out in the plan was not effective in relation to constipation and hydration.

i) The Registered Dietitian implemented a nutritional intervention for the management of constipation, however, an evaluation of the effectiveness of the intervention was not completed. The resident required four as needed medications for constipation in one month, six the subsequent month, and five the next month. An evaluation of the effectiveness of the nutrition intervention in relation to bowel medications was not completed.
ii) The resident's hydration status was not evaluated in relation to the resident's hydration goals. The resident met their fluid requirement on only eight days over a three month period, after which the resident was hospitalized. An evaluation of the resident's hydration did not occur in relation to the identified fluid goals and action was not taken to address the fluid intake that was below the identified target. The Nutrition Status Resident Assessment Protocol (RAP) identified the resident was consuming adequate fluids. An evaluation of the resident's fluid intake in relation to the assessed fluid requirements did not occur and action was not taken to address the fluid deficit below the identified fluid goals.

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(4)(a), 6(4)(b), to be implemented voluntarily.

WN #2: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

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. [O.Reg. 79/10, s. 50(2)(a)(i)]
The licensee did not ensure that resident #001 received a skin assessment by a member of the registered nursing staff within 24 hours of admission.
A) Resident #001 did not receive a skin assessment within 24 hours of admission. The first record, completed by registered nursing staff regarding the resident's skin was two days after admission, which noted the presence of a bruise, however no other assessment information was documented. A second entry was completed which noted that the PSW reported that the resident's skin was in good condition with a dressing on the skin which would be changed the following day. There was no record of a head to toe skin assessment within 24 hours of admission. [s. 50. (2) (a) (i)]

2. [O.Reg. 79/10, s. 50(2)(b)] Previously issued April 18, 2011 as a VPC, August 30, 2011 as a VPC
The licensee did not ensure that, all residents who exhibited 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.
A) Resident #004 sustained a skin injury, which required the treatment of a dressing. This area of altered skin integrity was documented in the progress notes, however there was no skin assessment conducted using a clinically appropriate assessment instrument.
B) Resident #001 was identified to have an open area on the skin which deteriorated the following month and skin breakdown subsequently identified on another area of the body. The areas of altered skin integrity were noted in the progress notes, however, were not initially assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

3. [O.Reg. 79/10, s. 50(2)(b)(iii)]
Not all residents who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, were assessed by a registered dietitian and changes were not made to the residents' plans of care relating to nutrition and hydration.
A) Resident #001 was not assessed by the Registered Dietitian in relation to skin until 1.5 months after the initial skin problem was identified. Progress notes identified skin breakdown with deterioration and subsequent development of additional open areas.

The resident was not assessed by the Registered Dietitian until 1.5 months after the initial skin breakdown was identified.
B) Resident #013 was noted to have several open areas on the skin over more than a two month period, however, an assessment related to the open areas was not completed by the dietitian. The dietitian assessed the resident related to weight loss 2.5 months after the initial skin concern was identified, however, the assessment did not mention problems with skin integrity.

4. [O.Reg. 79/10, s. 50(2)(b)(iv)]
Residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
A) Resident #001 was identified to have significant open areas on their skin. The areas of altered skin integrity were not assessed at least weekly by a member of the registered nursing staff.
B) Resident #004 sustained an injury to the skin. There was no additional information or assessment regarding this area of altered skin integrity in the clinical record. The area was observed to be covered with a dressing during the course of the inspection. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 003 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. 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. [O.Reg. 79/10, s. 68(2)(e)]
A weight monitoring system was not in place to measure and record resident weights on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter. The home's "Weight Monitoring policy V3-1510" was consistent with legislative requirements and stated weights would be taken within 24 hours of admission.
A) The home's weight monitoring system was not in place for resident #001 on admission. The resident's weight and height were not recorded until eight days after admission.
B) Resident #004 did not have their weight and height recorded until seven days after admission.
C) Resident #005 did not have their weight recorded until nine days after admission.
D) Resident #006 did not have their weight recorded until ten days after admission.
E) Resident #008 did not have their weight recorded until seven days after admission.
Progress notes and Point of Care charting for the residents did not identify rationale for the delayed weight records. Staff confirmed that the weights in the computer were the records the staff used (paper copies had been shredded and were not used as part of the resident's record).
F) A system to identify when re-weighs were completed was not consistently in place resulting in delays in action taken for weight changes.

Additional Required Actions:

CO # - 004 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. 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. [O.Reg. 79/10, s. 69]
A) Resident #001 had a significant weight loss of 5.3% over one month, however, an assessment using an interdisciplinary approach did not occur and action was not taken for another month until a referral to the Dietitian was completed related to poor skin integrity. The Registered staff and dietitian confirmed that a dietary referral related to the weight loss was not completed. The home's "Weight Monitoring V3-1510" policy stated that staff were to use the "Referral to Dietitian form" to refer an unplanned weight loss or gain of 5% in one month and to make a progress note entry that addresses any resident issues that may have contributed to the unplanned weight loss/gain, as well as referral made to the Registered Dietitian.
B) Resident #009 had a significant weight gain of 9% over one month, however, the weight change was not assessed. Staff confirmed that a multidisciplinary assessment of the significant weight change did not occur and a referral was not made to the registered dietitian for assessment of the weight gain. The resident had a subsequent significant weight gain of 9.4% over one month, however, the weight change was not assessed and action was not taken to address the weight gain as the registered dietitian questioned the accuracy of the significant weight gain and requested a re-weigh to verify the accuracy of the weight. The re-weigh, which confirmed the significant weight gain was delayed until the end of the month (policy stated that re-weighs were to be completed by the 5th of the month). The resident had further significant weight gain the next two months (26% weight gain over 5 months), however, the resident's weight gain had not been assessed or followed up since the initial re-weigh was requested. Staff interview confirmed the resident was still receiving high calorie interventions and the resident was consuming large quantities of high calorie items at meals, however, this was not assessed and interventions were not evaluated in relation to the resident's significant weight gain. The resident surpassed their goal weight range two months prior.

Additional Required Actions:

CO # - 005 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.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
  i. a physician,
  ii. a registered nurse,
  iii. a registered practical nurse,
  iv. a member of the College of Occupational Therapists of Ontario,
  v. a member of the College of Physiotherapists of Ontario, or
  vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 33(4)]
The use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in the resident's plan of care without: being approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, or a member of the College of Physiotherapists of Ontario, and consented to by the resident or the substitute decision-maker of the resident with authority to give that consent.

The home had a procedure in place titled, "Restraint and PASD Mechanical", last revised April 2013, which identified that PASD's were to have a "prescribing order" for authorization by the individual who approved the use of the device.
A) Records reviewed and staff interview confirmed that resident #001 was using a PASD on an ongoing basis. The resident did not have approval for the device as required.
B) Resident #001 had a Restraint Assessment completed. The Consent to Administer Restraint/PASD document was not signed by the family, as consent to use the device, until 14 days later. Statements obtained from the residents family confirmed that they were not consulted to consent to the use of the PASD when it was first initiated. [s. 33. (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 with s. 33(4), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 51(1)2]
Resident #013 received a diagnosis of constipation, however, the resident did not have nutrition and hydration protocols implemented. A referral to the registered dietitian related to constipation was initiated by nursing staff, however, follow up by the dietitian did not occur until one month after the initial referral. The dietitian stated that they did not receive the referral and came across it during a follow up for a different nutritional issue. The resident continued to have problems with constipation. [s. 51. (1) 2.]

2. [O.Reg. 79/10, s. 51(2)(f)]
The licensee did not ensure that there was a range of continence care products available and accessible to residents and staff at all times.

Several nursing staff interviewed identified that a certain style of incontinent care products were available in the home, only when provided by the resident/representative. A review of the clinical records for two residents confirmed the use of this style product and that they were supplied by the resident's families. Current management staff in the home were unaware of this practice when interviewed on August 29, 2013, and directed staff to contact the relevant families to inform them that the products would be provided to the residents, with an assessed need, at no charge, by the home. [s. 51. (2) (f)]

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 with ensuring there are treatments and interventions to prevent constipation, including nutrition and hydration protocols, s. 51(1)2, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 131(2)]
Drugs were not administered to resident #013 in accordance with the directions for use specified by the prescriber. The physician orders for bowel medications were not followed by staff providing care to the resident. [s. 131. (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 with ensuring drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 221(2)1]
The licensee did not ensure that all direct care staff received the required training, annually.
A) A review of the 2012 and 2013 In-Service Schedule/Plans identified that the home had offered education to direct care staff related to mental health issues, including caring for persons with dementia and behaviour management, and identified plans for additional opportunities. A review of the available Attendance Records from education sessions held in 2012 and to date in 2013 identified that not all direct care staff received this required retraining on an annual basis as required. This information was confirmed by the Administrator.
B) Not all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in continence care and bowel management. Staff education and training records did not reflect that education related to continence care and bowel management was provided for 2012 and had just been provided September 2013 with new management at the home. The Director of Care confirmed that education on bowel management and continence care had not been provided to all staff who provided direct care to residents. Personal Support Workers identified a need for education in this area during interview. [s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring all direct care staff receive the required training annually, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 233(1)]
The licensee did not ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.
A) The home was unable to provide a complete clinical record for resident #002 for the length of time the resident resided at the home. The clinical record provided incomplete progress notes. The current management at the home searched for the records however due to changes in the electronic software and staffing were unsuccessful in their attempts. [s. 233. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11]
Resident #002 did not consistently have the right to participate fully in the development, implementation, review and revision of their plan of care.
A) Interview with a Registered Nurse (RN) confirmed they completed a referral to specialized services for resident #002. This application was completed under the direction of the Director of Care (DOC). The staff confirmed they did not discuss the referral with the Power of Attorney (POA) (the resident was unable to make decisions regarding care), as this was the role of the DOC. Interview with additional staff, who were involved with the care of resident #002, identified that the DOC would not have obtained consent for this application or involved the POA in this revision to the resident's plan of care. [s. 3. (1) 11.]

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

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Issued on this 1st day of October, 2013

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

M Warriner, RO

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) :	MICHELLE WARRENER (107), LISA VINK (168)
Inspection No. / No de l'inspection :	2013_191107_0009
Log No. / Registre no:	H-000498-13, H-000249-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 25, 2013
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRANTFORD 389 WEST STREET, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~Shelly Desgagne~~ MW Susan Hastings MW

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2012_122156_0024, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The home shall ensure there is a written plan of care for each resident, including the identified resident, that sets out clear directions to staff and others who provide direct care to residents.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued August 30, 2011 as a CO, December 18, 2012 as a CO, January 9, 2013 as a CO
The plan of care for resident #013, related to constipation, did not set out clear directions for the staff and others who provided direct care to the resident. The resident's plan of care did not provide clear direction on what to do when problems occurred. The resident had concerns noted in the progress notes, however, it was not clear if further action was required. During interview staff voiced concerns over the resident and a need for further direction related to constipation. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_122156_0024, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents, including the identified residents, are reassessed and their plans of care revised when care needs change or the plan is ineffective. The licensee shall ensure an evaluation of the effectiveness of the plan of care in relation to identified goals when assessments are completed in relation to hydration and constipation.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)(c)] Previously issued Aug 30, 2011 as a CO, December 18, 2012 as a CO, January 9, 2013 as a CO
A) Resident #009 was not reassessed and their plan of care revised when the resident's care needs changed and the care set out in the plan was not effective in relation to hydration and constipation.
i) The resident had a 26% significant weight gain over a five month period, however, a re-assessment of the resident's hydration requirements in relation to the weight gain did not occur at the identified nutritional review. The resident was regularly documented as consuming less fluids than the previously assessed fluid requirement, however, an assessment of the resident's intake in relation to identified goals did not occur. The resident consumed less than their identified fluid requirement on numerous days over a four month period (61% of days the first month reviewed, 40% of days the subsequent month, 48% of days the next month, and 64% the next month), and had two periods of less than 12

servings over three consecutive days (the home's policy stated a referral to the dietitian was required for this), without a referral to the dietitian and without a documented assessment of the poor hydration below the identified goals for the resident. The resident's hydration plan of care was not revised in relation the weight gain or continued fluid intake below the established goal for the resident.
ii) Resident #009 was not reassessed and their plan of care reviewed and revised when the care set out in the plan was not effective in relation to constipation.
The resident had a plan of care requiring nutritional interventions daily for the treatment of constipation, however, an evaluation of the effectiveness of the nutrition intervention was not completed, and the resident continued to receive medical treatment for constipation. Constipation was noted at the RAI-MDS Nutritional Status RAP, however, the resident's dietary plan of care was not revised in relation to interventions for the prevention and treatment of constipation.
B) Resident #001 was not reassessed and their plan of care reviewed and revised when the care set out in the plan was not effective in relation to constipation and hydration.
i) The Registered Dietitian implemented a nutritional intervention for the management of constipation, however, an evaluation of the effectiveness of the intervention was not completed. The resident required four as needed medications for constipation in one month, six the subsequent month, and five the next month. An evaluation of the effectiveness of the nutrition intervention in relation to bowel medications was not completed.
ii) The resident's hydration status was not evaluated in relation to the resident's hydration goals. The resident met their fluid requirement on only eight days over a three month period, after which the resident was hospitalized. An evaluation of the resident's hydration did not occur in relation to the identified fluid goals and action was not taken to address the fluid intake that was below the identified target. The Nutrition Status Resident Assessment Protocol (RAP) identified the resident was consuming adequate fluids. An evaluation of the resident's fluid intake in relation to the assessed fluid requirements did not occur and action was not taken to address the fluid deficit below the identified fluid goals. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that each resident (including the identified residents) who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds;
A) 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
B) 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
C) that the areas are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated
The plan is to be submitted by October 4, 2013 to Long-Term Care Homes Inspector, Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 50(2)(b)] Previously issued April 18, 2011 as a VPC, August 30, 2011 as a VPC
The licensee did not ensure that, all residents who exhibited 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.
A) Resident #004 sustained a skin injury, which required the treatment of a dressing. This area of altered skin integrity was documented in the progress notes, however there was no skin assessment conducted using a clinically appropriate assessment instrument.
B) Resident #001 was identified to have an open area on the skin which deteriorated the following month and skin breakdown on another area of the body identified subsequently. The areas of altered skin integrity were noted in the progress notes, however, were not initially assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

[O.Reg. 79/10, s. 50(2)(b)(iii)]
Not all residents who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, were assessed by a registered dietitian and changes were not made to the residents' plans of care relating to nutrition and hydration.
A) Resident #001 was not assessed by the Registered Dietitian in relation to skin until 1.5 months after the initial skin problem was identified. Progress notes identified skin breakdown with deterioration and subsequent development of additional open areas. The resident was not assessed by the Registered Dietitian until 1.5 months after the initial skin breakdown was identified.
B) Resident #013 was noted to have several open areas on the skin over more than a two month period, however, an assessment related to the open areas was not completed by the dietitian. The dietitian assessed the resident related to weight loss 2.5 months after the initial skin concern was identified, however, the assessment did not mention problems with skin integrity. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that:
A) each resident's weight and height are taken promptly on admission and monthly, in compliance with the home's weight monitoring policy
B) re-weighs, to verify the accuracy of significant weight change, are completed according to the home's weight policy
C) a system is in place to identify when a re-weigh was completed
The plan is to be submitted by October 4, 2013 to Long-Term Care Homes Inspector, Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 68(2)(e)]
A weight monitoring system was not in place to measure and record resident weights on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter. The home's "Weight Monitoring policy V3-1510" was consistent with legislative requirements and stated weights would be taken within 24 hours of admission.
A) The home's weight monitoring system was not in place for resident #001 on admission. The resident's weight and height were not recorded until eight days after admission.
B) Resident #004 did not have their weight and height recorded until seven days after admission.
C) Resident #005 did not have their weight recorded until nine days after admission.
D) Resident #006 did not have their weight recorded until ten days after admission.
E) Resident #008 did not have their weight recorded until seven days after admission.
Progress notes and Point of Care charting for the residents did not identify rationale for the delayed weight records. Staff confirmed that the weights in the computer were the records the staff used (paper copies had been shredded and were not used as part of the resident's record).
F) A system to identify when re-weighs were completed was not consistently in place resulting in delays in action taken for weight changes. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that residents (including identified residents) with significant and/or unplanned, ongoing weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated. The plan is to be submitted by October 4, 2013, to Long-Term Care Homes Inspector, Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69]
A) Resident #001 had a significant weight loss of 5.3% over one month, however, an assessment using an interdisciplinary approach did not occur and action was not taken for another month until a referral to the Dietitian was completed for poor skin integrity. The Registered staff and dietitian confirmed that a dietary referral related to the weight loss was not completed. The home's "Weight Monitoring V3-1510" policy stated that staff were to use the "Referral to Dietitian form" to refer an unplanned weight loss or gain of 5% in one month and to make a progress note entry that addresses any resident issues that may have contributed to the unplanned weight loss/gain, as well as referral made to the Registered Dietitian.
B) Resident #009 had a significant weight gain of 9% over one month, however, the weight change was not assessed. Staff confirmed that a multidisciplinary assessment of the significant weight change did not occur and a referral was not made to the registered dietitian for assessment of the weight gain. The resident had a subsequent significant weight gain of 9.4% over one month, however, the weight change was not assessed and action was not taken to address the weight gain as the registered dietitian questioned the accuracy of the significant weight gain and requested a re-weigh to verify the accuracy of the weight. The re-weigh, which confirmed the significant weight gain was delayed until the end of the month (policy stated that re-weighs were to be completed by the 5th of the month). The resident had further significant weight gain the next two months (26% weight gain over 5 months), however, the resident's weight gain had not been assessed or followed up since the initial re-weigh was requested. Staff interview confirmed the resident was still receiving high calorie interventions and the resident was consuming large quantities of high calorie items at meals, however, this was not assessed and interventions were not evaluated in relation to the resident's significant weight gain. The resident surpassed their goal weight range two months prior. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

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 25th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : M Warrener, CO

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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