Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 20, 2019	2019_792659_0011	020622-17, 023877-17, 023932-17, 002359-18, 006899-18, 007575-18, 022525-18, 024517-18, 026077-18, 029348-18, 029592-18, 000661-19, 003121-19	Critical Incident System

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street New Hamburg ON N3A 2K4

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

Nithview Home
200 Boullee Street New Hamburg ON N3A 2K4

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

JANETM EVANS (659), KRISTAL PITTER (735), MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 15, 16, 17, 21, 22, 23,

24, 27, 28, 29, 30 and 31, 2019.

The following intakes were completed as part of the inspection:
Log #000661-19\Follow up to CO#001 from inspection #2018_735659_0019, CDD Feb 28, 2019
Log#003121-19\Follow up to CO#001 from inspection #2019_755728_001, CDD April 12, 2019
Log # 023877-17\C547-000011-17 Critical Incident related to Alleged abuse
Log #020622-17\16617/C547-000009-17 Critical Incident related to Alleged abuse and Medication Administration
Log#023932-17\C54-000012-17 Critical Incident related to Alleged Abuse
Log #029592-18\AH IL-61487-AH/C547-000033-18 Critical Incident related to Alleged Abuse
Log #029348-18\CI C547-000032-18 Critical Incident related to Responsive Behaviours
Log#002359-18\18403/C547-000007-18 Critical Incident related Alleged abuse and Responsive Behaviours
Log#022525-18\C547-000024-18 Critical Incident related to Alleged abuse
Log #026077-18IL-60264-AH/C547-000028-18 Critical Incident related to Alleged abuse
Log #007575-18\C547-000013-18 Critical Incident related to Falls
Log #006899-18\C547-000012-18 Critical Incident related to Falls
Log #024517-18\IL-59597-AH/C547-000026-18 Critical Incident related to Skin and Wound

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Executive Director (ED), former Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument Coordinator (RAI C), Behavioural Support Ontario staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Scheduler, Restorative Care.

Observations were completed with general care and cleanliness of the home and residents, resident to resident interactions, staff to resident interactions, resident care, call bells and bed alarms.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #001	2019_755728_0001	728

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	Légende 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. This inspection was completed as follow-up to CO #001 from inspection

#2018_73659_0019, related to O. Reg 79/10 s. 33. (1), issued December 28, 2019 with a CDD of February 28, 2019.

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice.

Three PSWs, and two ADOCs stated residents were to receive two baths per week. The PSWs stated that baths were to be documented on Point of Care (POC). Two PSWs stated that if a resident missed a bath they document this in the communication book and notified the RPN. A PSW stated if a resident missed a bath they document "not applicable" or refused on POC as there was no other option. If there was time, they may try to pick up and complete a missed bath but often they did not have time. The former DOC stated if a bath was missed it should be reported to the RPN and written in the communication book. They said that this did not happen consistently. An ADOC stated that a 'blank' in the documentation for bathing meant either the staff did not do the charting or the resident did not receive a bath.

Observations completed showed each resident home area had a bathing schedule which was posted at the nursing station and each resident was assigned two baths/showers per week.

The 24 hour Resident Communication record was kept at the nursing station on each unit. Review of this book showed documentation of seven identified residents who had missed a bath/shower in a one week period. In some instances a notation was left that this was due to staff working short.

The Documentation Survey report for bathing was reviewed for an 11 week period in 2019, it identified the following:
(i) An identified resident received eight of 22 baths. There was a span of 27 days where the resident was not bathed.
(ii) An identified resident received nine of 22 baths.
(ii) An identified resident received 20 of 22 baths.
(iv) An identified resident received 15 of 22 baths.
(v) An identified resident received 12 of 22 baths. On four occasions it was documented the resident had refused the bath. On one occasion the resident had not been bathed according to their preference. There was a span of 13 days and a span of 10 days the resident was not bathed.
(vi) An identified resident received 14 of 22 baths. In one instance the resident was not

bathed according to their preference. There was a span of nine, 14 and 18 days the resident had not received a bath. In one instance the resident was not bathed according to their preference.
(vii) An identified resident received 10 of 22 baths. On two instances it was documented the resident refused. On six instances the resident was not bathed according to their preference. There was a span of 13 and 16 days where the resident had not received a bath.

One identified resident stated that they usually had a tub bath and that the frequency of the bath varied; sometimes it was once a week other times it seemed like it was day after day. A second identified resident said they could not recall the frequency of when they were bathed but they would prefer to have two baths per week

The ADOC and CEO acknowledged residents had not received a minimum of two baths/showers per week according to their preference.

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC), related to a resident to resident altercation.

One identified resident's plan of care documented that they had responsive behaviours when other residents entered their personal space. A specified intervention was to be in place to ensure the safety of other residents. Point of Care (POC) documentation for the specified date, did not include documentation that this intervention was in place.

The co-resident's plan of care documented that the resident exhibited a specified behaviour. Their respective responsive behaviours were a trigger for each other.

The home had not investigated to ensure that the intervention was in place at the time of the incident.

The ADOC said that when POC documentation was left blank, it meant that the intervention was not in place.

The licensee failed to ensure that care was provided to the resident as outlined in the plan of care on the specified date.

B. A CI was submitted to the MOHLTC, related to a safety device being unplugged for six residents.

The home completed an investigation that determined that a PSW had unplugged the identified residents' safety device.

The ADOC said that after reviewing their records related to the safety device, and from the RN and former DOC observations, it was determined that the safety devices were unplugged by a PSW. They said that there was no harm to the residents involved.

The plan of care for the identified residents stated the residents were at risk for falls and they were to have a safety device in place to mitigate this risk. One resident's plan of care documented that the safety device was to be checked by staff to ensure that it was working. The home's investigative notes determined that the safety devices were unplugged on the night shift of a specified date.

The licensee failed to ensure that the intervention of the safety device was in place for the six residents' on a specified date, as specified in their plan of care.

C. A CI was submitted to the MOHLTC, which documented that an identified resident sustained a fall that resulted in an injury.

The home's documentation indicated that a PSW and RPN had been assisting the identified resident. The RPN left to obtain supplies with the expectation that the PSW would remain and monitor the resident for safety. The PSW did not remain to monitor the resident. Once they left the resident fell while engaging in an activity of daily living.

The identified resident's plan of care directed staff that the resident participated actively in Activities of Daily Living and one staff member was required to provide non-weight bearing physical assistance to the resident.

The home completed an investigation that determined that the PSW did not provide the identified resident with the care required. The ADOC said that the resident was put at risk because the PSW did not remain with the resident.

The licensee failed to ensure that the identified resident was provided with the required assistance as set out in the plan of care.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI was submitted to the MOHLTC related to a worsening area of altered skin integrity with no assessment or treatment.

Review of POC follow up question for the identified resident related to skin observation, documented an area of altered skin integrity which was noted on a specified date. The follow up questions for where the altered skin integrity was located or if the skin condition was reported to the registered staff was not answered. In two instances it was documented "not applicable" for a skin observation completed by PSWs.

Skin and wound progress notes for three specified dates, documented the identified resident had a pre-existing area of altered skin integrity.

On a specified date, a PSW had entered a note in the 24 hour Resident Condition report related to a new area of altered skin integrity for the identified resident. Over the next 13 days, three additional entries were made in the 24 hour Resident Condition report

describing the area of altered skin integrity as worsening, and that the RPN had been notified of the area of altered skin integrity.

Review of the assessment tab on Point Click Care (PCC) showed that a skin assessment was completed by the RN, 16 days after the altered skin integrity was first identified.

The home's Skin and Wound Care Management Protocol, VII - G-10.80, current revision April 2016, stated that Registered staff were to:
-conduct a skin assessment; provide immediate and interventions to reduce or relieve pain, promote healing and prevent infection; update plan of care including the TAR and care pain and
-if the wound was worsening or was not responding to treatment, initiate an electronic referral form.

Two RPNs, the RAI C and ADOC stated that usually the PSW was the first to identify a skin and wound issue and would report this to the RPN. The RPN was responsible to assess the area of altered skin integrity and document a Skin and Wound assessment under the assessment tab on PCC.

A PSW stated that prior to going on vacation, they observed the identified resident with a new area of altered skin integrity. When they returned from vacation and were assisting a co-worker to provide care to the resident, they noted the area of altered skin integrity had worsened. This was reported to ADOC.

The RAI C stated that the identified resident had not received a skin assessment by the registered staff using a clinically appropriate assessment tool at the time the altered skin integrity was reported.

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity received immediate treatment and interventions to promote healing.

A Critical Incident was submitted to the MOHLTC related to a worsening area of altered skin integrity for an identified resident with no assessment or treatment.

Review of follow up question report for a two month period, documented "not applicable" for a skin observation by PSWs on two instances. On a specified date it was documented there was an area of altered skin noted, but the site was not identified and there was no documentation that the Registered staff were notified.

The home's investigation showed that on a specified date a PSW documented the identified resident had a new area of altered skin integrity and entered a note in the 24 hour resident condition report. Over the next 13 days, three additional entries were made in the 24 hour Resident Condition report describing that the area of altered skin integrity was worsening and that the RPN had been notified. On the 13th day following the identification of the area of altered skin integrity, the PSW notified the day RPN the identified resident's area of altered skin integrity had worsened; the RPN advised them to provide a specified treatment. The PSW was not satisfied with the response and informed the evening RPN, who also advised the PSW to provide the same treatment. On the 14th day, a progress note entry completed by an RPN stated the area of altered skin integrity was checked and it had not worsened. On the 16th day, the PSW wrote a note to the ADOC about the identified resident's worsening area of altered skin integrity. The ADOC and RAI C/former Skin and Wound lead assessed the area of altered skin integrity and found that it had worsened.

Review of the eTAR and eMAR did not show documentation of interventions for a skin and wound assessment until 16 days after the area of altered skin integrity had been identified. At that point, treatment was added to the eTAR.

Review of the resident's plan of care for impaired skin integrity, showed numerous interventions were in place.

The RAI C stated that they first became aware of the area of altered skin integrity 16 days following its identification by the PSW. The registered staff were responsible to put interventions in place when the altered skin integrity was first identified, and the eTAR should have had a weekly Skin and Wound Assessment completed as well as an order for treatment. They acknowledged interventions had not been put in place to promote healing of the altered skin integrity when it was identified and that during that two week period the area of altered skin integrity worsened. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Review of the skin and wound tracking for a four month period, showed an identified resident was documented as having a worsening area of altered skin integrity.

Skin and Wound Care Assessment completed December 2018, documented the identified resident had an area of altered skin integrity on a specified site site.

There was no documentation noted in the December 2018, electronic Treatment Administration Record (eTAR) related to this area of altered skin integrity.

In January 2019, the eTAR documented weekly skin assessments of the area of altered skin integrity were to be completed one time per day on Saturdays. Documentation showed this was signed on the eTAR as completed each week in January 2019.

Review of Skin and Wound Care assessments on PCC did not show documented evidence of a Skin and Wound Care assessment completed for one of the specified dates.

An RPN and the ADOC stated that skin and wound assessments were to be completed weekly and documented in PCC tab under the header of skin and wound assessments. They stated that an alert should be documented in the eTAR for when the assessment was due to be completed.

The RPN and ADOC reviewed the skin and wound assessments in PCC and acknowledged the resident had not had a weekly skin and wound assessment completed on a specified date and that a weekly skin and wound assessment should have been completed.

B. Review of the skin and wound tracking for a four month period in 2019, showed the identified resident was documented as having a worsening area of altered skin integrity and being provided with treatment.

Within a one week period, in the first month, the identified resident's area of altered skin integrity as worsened.

The eTAR documentation showed weekly Skin and Wound Assessments were initiated in the first month.

Review of the Weekly Skin and Wound Assessments on PCC showed no evidence for an assessment on three instances over the four months.

The RPN, RAI C and ADOC said that a weekly Skin and Wound assessment should be

documented in PCC under the Skin and Wound assessment tab. The ADOC reviewed the resident's Skin and Wound Care assessments on PCC and acknowledged there was no documented Skin and Wound assessment completed on three instances.

The licensee has failed to ensure that the identified residents, who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was cared for in a manner consistent with his or her care needs.

Two CI's were received by the MOHLTC related to an identified resident not receiving the assistance they required for ADL's and staff not providing a call bell for the resident to call for assistance.

The identified resident was assessed as requiring assistance from one staff for an ADL task.

The plan of care stated the resident was to have some way of calling for assistance. This was later updated to state that one staff should remain with the resident for the ADL.

For one of the incidents, the home's investigation showed that the identified resident was left by a PSW during the performance of their ADL, and the resident's call bell was not within the resident's reach. The resident had been left for approximately 20 minutes prior to staff checking to see if the resident would like assistance.

In the second instance, a PSW had left an identified resident alone during the performance of their ADL, and left at the end of their shift without checking to see if the resident had required assistance. The resident had rung their call bell and called out for approximately 50 minutes before someone came and assisted them.

The PSWs involved in the incident stated the identified resident required assistance from one staff for the ADL.

One PSW recalled assisting the resident and leaving them with their call bell in proximity; they acknowledged they left at the end of their shift and had not returned to see if the identified resident required assistance.

The second PSW said they had assisted the identified resident with initiation of the ADL and left them to provide assistance to co-residents. They had forgotten to return to the identified resident and they acknowledged that the resident had been unable to reach the call bell to call for assistance.

The license failed to ensure that the identified resident was cared for in a manner consistent with their care needs. [s. 3. (1) 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 the identified resident receives care in a manner consistent with their assessed care needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Ontario Regulation 79/10 defines physical abuse as physical force by anyone other than a resident that caused physical injury or pain. Verbal abuse is defined as any form of communication of threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished the resident's sense of well-being, dignity, or self-worth , that is made by anyone other than a resident.

A. A CI was submitted to the MOHLTC related to an incident of alleged staff to resident abuse.

The home's documentation stated that two PSWs heard the identified resident yelling from their room and went to investigate. The home's investigative notes documented that a PSW who had been providing care to the identified resident quickly removed their hands from the identified resident and indicated that the resident was being resistive with care. The home's documentation stated that the PSW providing care had a rude and harsh tone when working with the identified resident.

The identified resident's progress notes documented that they sustained an injury as a

result of the incident.

Two PSWs told Inspector #733 that the PSW working with the identified resident used a tone that was rude and harsh and that the resident had been upset by the interaction. They said that they considered this incident to be abuse.

The ADOC said that after completing an investigation of the incident, they determined that verbal and physical abuse had occurred.

The licensee failed to protect the identified resident from abuse.

B. A CI was submitted to the MOHLTC related to an incident of resident to resident abuse.

The CI documented that an identified resident was injured by a co-resident after entering their room.

A review of the identified resident and co-resident's progress notes indicated that there had been a history of incidents where the identified resident had exhibited a responsive behaviour; this would trigger a responsive behaviour for the co-resident.

Interventions were in place for the identified resident at the time of the incident; as well as for the co-resident.

The BSO RPN said that the identified resident and co-resident had responsive behaviours that triggered each other and that there was a history prior to this incident. The ADOC and BSO RPN said that they considered this incident to be abuse.

The licensee failed to ensure that identified resident was protected from abuse by anyone. [s. 19. (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 to ensure that residents' are protected from abuse by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CI was submitted to the MOHLTC, related to an incident of alleged staff to resident abuse.

The home's policy titled Prevention of Abuse and Neglect of a Resident, policy #VII-G-10.00, last revised January 2015, directed the ED/Administrator or designate to determine whether the employee should be sent home immediately.

The home's documentation stated that two PSWs informed the RPN of an incident of witnessed physical and verbal abuse toward an identified resident.

Progress notes documented that the RPN notified the RN in the building and on-call management staff immediately.

One of the PSW's said that they were surprised to see that the alleged abuser was working following the incident, when the investigation had not yet been completed.

The home's staffing assignment documented that the identified staff member had worked an evening shift following the report of alleged abuse. The Scheduler said that based on the schedule, the staff member likely did work on the specified date.

Payment records identifed that the staff member was paid for their shift on the specified date.

The ADOC said that staff were to be placed on administrative leave when there was an investigation being completed related to abuse of a resident. The former DOC said that the identified staff member did work on the specified date, and they should not have worked based on their zero tolerance of abuse policy.

The licensee has failed to ensure that the agency PSW was placed on administrative leave, as directed by their policy. [s. 20. (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 to ensure that licensee complies with their abuse policy with respect to the ED/Administrator or designate determining whether an employee should be sent home immediately following involvement in an alleged incident of abuse,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A. A CI was submitted to the MOHLTC, for an incident of alleged neglect.

The CEO reviewed the CI and acknowledged that the incident should have been reported immediately to the Director but it was not.

B. A CI was submitted to the MOHLTC related to an incident of alleged resident to resident abuse

The ED acknowledged that the CI should have been reported immediately to the Director and it had not been.

The licensee failed to ensure that this incident of alleged abuse was reported immediately to the Director. [s. 24. (1)]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), KRISTAL PITTER (735), MARIA MCGILL (728)
Inspection No. / No de l'inspection :	2019_792659_0011
Log No. / No de registre :	020622-17, 023877-17, 023932-17, 002359-18, 006899-18, 007575-18, 022525-18, 024517-18, 026077-18, 029348-18, 029592-18, 000661-19, 003121-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 20, 2019
Licensee / Titulaire de permis :	Tri-County Mennonite Homes 200 Boullee Street, New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	Nithview Home 200 Boullee Street, New Hamburg, ON, N3A-2K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Eros

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Tri-County Mennonite Homes, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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: 2018_735659_0019, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must comply with s. 33 (1) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that each resident of the home is bathed at a minimum, twice a week by the method of his or her choice and there is documentation of the bathing.
b) Ensure that the resident's plan of care has their bathing preference documented.
c) Develop, document and implement a monthly audit of bathing on all units to ensure bathing is completed.
d) Conduct an analysis of the bathing audits by unit and identify and implement actions to address deficiencies in the audit including missed baths. Written records of the analysis and actions implemented are to be shared with the ED and kept in the home.

Grounds / Motifs :

1. The licensee has failed to comply with C0 #001 from inspection #2018_73659_0019, related to O. Reg 79/10 s. 33. (1),issued December 28, 2019 with a CDD of February 28, 2019.

The licensee was ordered to:
a) Ensure that each resident of the home is bathed at a minimum, twice a week by the method of his or her choice and there is documentation of the bathing.
b) Ensure there is a documented system in place for tracking and making up

missed baths, and that the system is implemented.
c) Ensure that items a) and b) are communicated to front line staff.

The licensee failed to complete a, b and c.

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice.

Three PSWs, and two ADOCs stated residents were to receive two baths per week. The PSWs stated that baths were to be documented on Point of Care (POC). Two PSWs stated that if a resident missed a bath they document this in the communication book and notified the RPN. A PSW stated if a resident missed a bath they document "not applicable" or refused on POC as there was no other option. If there was time, they may try to pick up and complete a missed bath but often they did not have time. The former DOC stated if a bath was missed it should be reported to the RPN and written in the communication book. They said that this did not happen consistently. An ADOC stated that a 'blank' in the documentation for bathing meant either the staff did not do the charting or the resident did not receive a bath.

Observations completed showed each resident home area had a bathing schedule which was posted at the nursing station and each resident was assigned two baths/showers per week.

The 24 hour Resident Communication record was kept at the nursing station on each unit. Review of this book showed documentation of seven identified residents who had missed a bath/shower in a one week period. In some instances a notation was left that this was due to staff working short.

The Documentation Survey report for bathing was reviewed for an 11 week period in 2019, it identified the following:
(i) An identified resident received eight of 22 baths. There was a span of 27 days where the resident was not bathed.
(ii) An identified resident received nine of 22 baths.
(ii) An identified resident received 20 of 22 baths.
(iv) An identified resident received 15 of 22 baths.
(v) An identified resident received 12 of 22 baths. On four occasions it was

documented the resident had refused the bath. On one occasion the resident had not been bathed according to their preference. There was a span of 13 days and a span of 10 days the resident was not bathed.
(vi) An identified resident received 14 of 22 baths. In one instance the resident was not bathed according to their preference. There was a span of nine, 14 and 18 days the resident had not received a bath. In one instance the resident was not bathed according to their preference.
(vii) An identified resident received 10 of 22 baths. On two instances it was documented the resident refused. On six instances the resident was not bathed according to their preference. There was a span of 13 and 16 days where the resident had not received a bath.

One identified resident stated that they usually had a tub bath and that the frequency of the bath varied; sometimes it was once a week other times it seemed like it was day after day. A second identified resident said they could not recall the frequency of when they were bathed but they would prefer to have two baths per week

The ADOC and CEO acknowledged residents had not received a minimum of two baths/showers per week according to their preference.

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice.

The severity of this issue was one, no harm or no risk; the scope of this issue was three, widespread. The compliance history was five, as the Compliance order was being re-issued related to the same subsection and there were four or more compliance orders in the last 36 months. Compliance Order #001 was issued February 6, 2019, during inspection 2018_735659_0019 with a compliance due date of February 28, 2019. A Voluntary Plan of correction was issued August 14, 2018, during inspection #2018_750539_0005. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 6.7 of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that the identified resident has the specified intervention in place to ensure the safety of other residents.
b) Ensure that the six identified residents and all other resident's who use the safety device to mitigate risk of falls, have the safety device plugged in and functional.
c) Ensure that the identified resident and all resident's are provided with the required assistance for care as set out in the plan of care.

Grounds / Motifs :

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

A. A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC), related to a resident to resident altercation.

One identified resident's plan of care documented that they had responsive behaviours when other residents entered their personal space. A specified intervention was to be in place to ensure the safety of other residents. Point of Care (POC) documentation for the specified date, did not include documentation that this intervention was in place.

The co-resident's plan of care documented that the resident exhibited a specified behaviour. Their respective responsive behaviours were a trigger for each other.

The home had not investigated to ensure that the intervention was in place at the time of the incident.

The ADOC said that when POC documentation was left blank, it meant that the intervention was not in place.

The licensee failed to ensure that care was provided to the resident as outlined in the plan of care on the specified date.

B. A CI was submitted to the MOHLTC, related to a safety device being unplugged for six residents.

The home completed an investigation that determined that a PSW had unplugged the identified residents' safety device.

The ADOC said that after reviewing their records related to the safety device, and from the RN and former DOC observations, it was determined that the safety devices were unplugged by a PSW. They said that there was no harm to the residents involved.

The plan of care for the identified residents stated the residents were at risk for falls and they were to have a safety device in place to mitigate this risk. One resident's plan of care documented that the safety device was to be checked by staff to ensure that it was working. The home's investigative notes determined that the safety devices were unplugged on the night shift of a specified date.

The licensee failed to ensure that the intervention of the safety device was in place for the six residents' on a specified date, as specified in their plan of care.

C. A CI was submitted to the MOHLTC, which documented that an identified resident sustained a fall that resulted in an injury.

The home's documentation indicated that a PSW and RPN had been assisting the identified resident. The RPN left to obtain supplies with the expectation that the PSW would remain and monitor the resident for safety. The PSW did not

remain to monitor the resident. Once they left the resident fell while engaging in an activity of daily living.

The identified resident's plan of care directed staff that the resident participated actively in Activities of Daily Living and one staff member was required to provide non-weight bearing physical assistance to the resident.

The home completed an investigation that determined that the PSW did not provide the identified resident with the care required. The ADOC said that the resident was put at risk because the PSW did not remain with the resident.

The licensee failed to ensure that the identified resident was provided with the required assistance as set out in the plan of care.

The severity of this issue was three, actual harm or actual risk. The scope of the issue was two, pattern. The compliance history for this issue was three as there were previous non compliance to the same subsection, or section. During inspection # 2018_750539_0004 dated August 14, 2018, a Voluntary plan of correction was issued; during inspection # 2017_601532_0003 dated March 7, 2017, a voluntary plan of correction was issued; and during 2016_226192_0028, dated October 20, 2016, a voluntary plan of correction was issued. (728)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2019

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. 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 must be compliant with s 50. (2) (b) of the legislation.

Specifically, the licensee must ensure each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
a) receives a skin assessment by a member of the registered nursing, when the altered skin integrity is identified, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
b) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required
d) is reassessed at least weekly by a member of the registered staff, if clinically indicated

Grounds / Motifs :

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

A CI was submitted to the MOHLTC related to a worsening area of altered skin integrity with no assessment or treatment.

Review of POC follow up question for the identified resident related to skin observation, documented an area of altered skin integrity which was noted on a specified date. The follow up questions for where the altered skin integrity was located or if the skin condition was reported to the registered staff was not answered. In two instances it was documented "not applicable" for a skin observation completed by PSWs.

Skin and wound progress notes for three specified dates, documented the identified resident had a pre-existing area of altered skin integrity.

On a specified date, a PSW had entered a note in the 24 hour Resident Condition report related to a new area of altered skin integrity for the identified resident. Over the next 13 days, three additional entries were made in the 24 hour Resident Condition report describing the area of altered skin integrity as worsening, and that the RPN had been notified of the area of altered skin

integrity.

Review of the assessment tab on Point Click Care (PCC) showed that a skin assessment was completed by the RN, 16 days after the altered skin integrity was first identified.

The home's Skin and Wound Care Management Protocol, VII - G-10.80, current revision April 2016, stated that Registered staff were to:
-conduct a skin assessment; provide immediate and interventions to reduce or relieve pain, promote healing and prevent infection; update plan of care including the TAR and care pain and
-if the wound was worsening or was not responding to treatment, initiate an electronic referral form.

Two RPNs, the RAI C and ADOC stated that usually the PSW was the first to identify a skin and wound issue and would report this to the RPN. The RPN was responsible to assess the area of altered skin integrity and document a Skin and Wound assessment under the assessment tab on PCC.

A PSW stated that prior to going on vacation, they observed the identified resident with a new area of altered skin integrity. When they returned from vacation and were assisting a co-worker to provide care to the resident, they noted the area of altered skin integrity had worsened. This was reported to ADOC.

The RAI C stated that the identified resident had not received a skin assessment by the registered staff using a clinically appropriate assessment tool at the time the altered skin integrity was reported.
(659)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity received immediate treatment and interventions to promote healing.

A Critical Incident was submitted to the MOHLTC related to a worsening area of altered skin integrity for an identified resident with no assessment or treatment.

Review of follow up question report for a two month period, documented "not

applicable" for a skin observation by PSWs on two instances. On a specified date it was documented there was an area of altered skin noted, but the site was not identified and there was no documentation that the Registered staff were notified.

The home's investigation showed that on a specified date a PSW documented the identified resident had a new area of altered skin integrity and entered a note in the 24 hour resident condition report. Over the next 13 days, three additional entries were made in the 24 hour Resident Condition report describing that the area of altered skin integrity was worsening and that the RPN had been notified. On the 13th day following the identification of the area of altered skin integrity, the PSW notified the day RPN the identified resident's area of altered skin integrity had worsened; the RPN advised them to provide a specified treatment. The PSW was not satisfied with the response and informed the evening RPN, who also advised the PSW to provide the same treatment. On the 14th day, a progress note entry completed by an RPN stated the area of altered skin integrity was checked and it had not worsened. On the 16th day, the PSW wrote a note to the ADOC about the identified resident's worsening area of altered skin integrity. The ADOC and RAI C/former Skin and Wound lead assessed the area of altered skin integrity and found that it had worsened.

Review of the eTAR and eMAR did not show documentation of interventions for a skin and wound assessment until 16 days after the area of altered skin integrity had been identified. At that point, treatment was added to the eTAR.

Review of the resident's plan of care for impaired skin integrity, showed numerous interventions were in place.

The RAI C stated that they first became aware of the area of altered skin integrity 16 days following its identification by the PSW. The registered staff were responsible to put interventions in place when the altered skin integrity was first identified, and the eTAR should have had a weekly Skin and Wound Assessment completed as well as an order for treatment. They acknowledged interventions had not been put in place to promote healing of the altered skin integrity when it was identified and that during that two week period the area of altered skin integrity worsened. [s. 50. (2) (b) (ii)]

(659)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Review of the skin and wound tracking for a four month period, showed an identified resident was documented as having a worsening area of altered skin integrity.

Skin and Wound Care Assessment completed December 2018, documented the identified resident had an area of altered skin integrity on a specified site site.

There was no documentation noted in the December 2018, electronic Treatment Administration Record (eTAR) related to this area of altered skin integrity.

In January 2019, the eTAR documented weekly skin assessments of the area of altered skin integrity were to be completed one time per day on Saturdays. Documentation showed this was signed on the eTAR as completed each week in January 2019.

Review of Skin and Wound Care assessments on PCC did not show documented evidence of a Skin and Wound Care assessment completed for one of the specified dates.

An RPN and the ADOC stated that skin and wound assessments were to be completed weekly and documented in PCC tab under the header of skin and wound assessments. They stated that an alert should be documented in the eTAR for when the assessment was due to be completed.

The RPN and ADOC reviewed the skin and wound assessments in PCC and acknowledged the resident had not had a weekly skin and wound assessment completed on a specified date and that a weekly skin and wound assessment should have been completed.

B. Review of the skin and wound tracking for a four month period in 2019,

showed the identified resident was documented as having a worsening area of altered skin integrity and being provided with treatment.

Within a one week period, in the first month, the identified resident's area of altered skin integrity as worsened.

The eTAR documentation showed weekly Skin and Wound Assessments were initiated in the first month.

Review of the Weekly Skin and Wound Assessments on PCC showed no evidence for an assessment on three instances over the four months.

The RPN, RAI C and ADOC said that a weekly Skin and Wound assessment should be documented in PCC under the Skin and Wound assessment tab. The ADOC reviewed the resident's Skin and Wound Care assessments on PCC and acknowledged there was no documented Skin and Wound assessment completed on three instances.

The licensee has failed to ensure that the identified residents, who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The severity of this issue was three, actual harm or actual risk. The scope of the issue was three, widespread. The compliance history for the home was a three, as there were previous incidents of non compliance to the same subsection. During inspection 2018_750539_0004, dated August 14, 2018, a voluntary plan of correction was issued; during inspection #2017_601532_0003, dated June 27, 2017, a voluntary plan of correction was issued; during inspection #2016_226192_0028, dated October 20, 2016 a voluntary plan of correction was issued and during inspection #2016_226192_0026, dated August 24, 2016, a voluntary plan of correction was issued. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2019

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Central West Service Area Office