Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

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

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

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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 24, 2016; | 2016_511586_0004 (A1) | 015211-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

Ontario

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**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

JESSICA PALADINO (586) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**LTCH requested extension to compliance dates.**

**Issued on this 24 day of August 2016 (A1)**

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

**Original report signed by the inspector.**

Ontario

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

JESSICA PALADINO (586) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): July 20, 21, 22, 25, 26, 27, 28, 29, August 2, 3 and 4, 2016.**

**The following Critical Incident inspections (CIS) were completed simultaneously during this RQI:**

**007463-15 (Falls Prevention)**

**009777-15 (Food Quality)**

**013119-16 (Medication)**

**013607-16 (Prevention of Abuse & Neglect)**

**020313-16 (Falls Prevention)**

**022819-16 (Prevention of Abuse & Neglect)**

**The following Complaint Inspections were completed simultaneously during this RQI:**

**004233-15 (Personal Support Services, Accommodation Services - Maintenance)**

**015575-15 (Personal Support Services)**

**031609-15 (Food Quality; Dignity, Choice & Privacy)**

**022019-16 (Falls Prevention; Medication)**

**The following Follow Up Inspections were completed simultaneously during this RQI:**

**007682-15 (Nutrition & Hydration)**

**016657-15 (Nutrition & Hydration)**

**016658-15 (Nutrition & Hydration)**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assisant Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Staffing Coordinator, Resident Services Coordinator, Recreation Manager, Dietary Manager, a representative from "Motion Specialists", Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, Family and Resident Council representatives, residents and family members.**

**During the course of the inspection, inspectors reviewed resident health records, investigative notes, complaints logs and files, menus and dietary sheets, programme evaluations, policies and procedures; toured the home; and observed dining services, residents and care.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

**Dining Observation**

**Falls Prevention**

**Family Council**

**Food Quality**

**Hospitalization and Change in Condition**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Residents' Council**

**Skin and Wound Care**

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

- **10 WN(s)**
- **2 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 |
|---|---|---|---|
| LTCHA, 2007 s. 3. (1) | CO #001 | 2015_190159_0014 | 586 |
| LTCHA, 2007 s. 6. (7) | CO #002 | 2015_190159_0014 | 586 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's medication policy was complied with.

A) The home's Medication/Treatment Standards policy "Medication Administration" (policy number LTC-F-20, last reviewed January 2016) indicated that "Medications must remain in the original labeled container(s) or package(s) provided by the pharmacy service provider or the Government supply until administered to a resident", and "medications will not be prepared in advance (pre-poured) under any circumstances".

During the initial tour of the home on July 20, 2016, the Long-Term Care Homes (LTC) Inspector observed RPN #102 taking medications out of the medication cart, crushing them and placing them into disposable cups located on their medication cart. During interview the RPN confirmed that they were pre-pouring medications for resident #037 and resident #048 simultaneously, and at least one medication was classed as narcotic. The RPN stated that they were not aware that pre-pouring medications for more than one resident was not according to the home's policy for medication administration or the College of Nurses Standards. The DOC was asked to attend the medication pass and confirmed that RPN #102 had not followed the home's policy for medication administration by simultaneously pre-pouring medications for two residents. The DOC stated that the medications were discarded and the RPN was instructed regarding the home's policy for medication administration.

B) During review of the home's investigative notes for a CIS Inspection regarding a narcotic that went missing, RPN #104 confirmed that they were "pre-pouring"

medications for more than one resident when a narcotic was placed in the wrong resident's medication cup. The DOC confirmed that the RPN should not have been pre-pouring medications as the home's policy directed staff not to prepare medications in advance and to complete the medication pass for one resident before moving on to the next. [s. 8. (1) (b)]

2. The licensee failed to ensure that the home's Personal Assistive Services Devices (PASD) policy was complied with.

The home's Rehabilitation and Restorative Care policy "Personal Assistive Services Devices (PASD)/Assistive Devices" (policy number LTC-J-30, last reviewed August 2012) directed staff to "ensure the device is used as per manufacturer's instructions". Review of manufacturer's instructions for the Velcro lap belt did not include directions to staff for application. However, during interview, the home's vendor representative indicated that Velcro front release lap belts were to be applied to within two finger widths from the resident's torso.

In addition, the home's Resident Safety policy "Medical Devices and Safety" (policy number LTC-K-150, last reviewed May 2013) directed staff that "All malfunctioning medical devices and or equipment will be immediately tagged and taken out of service." According to their health record, resident #037 was at risk for falls and required the use of a specific PASD, from which the resident demonstrated their ability to release themselves.

The resident's PASD was noted to be loose on four occasions spanning between July 20 and 25, 2016. The staff would tighten the PASD but it would later become loosened again. RPN #100 confirmed that the resident's movement caused the PASD to become loosened.

During interview, PSW #101 reported that the PASD was loose each time they went to monitor the resident on June 25, 2016, and that they had reported it to RPN #100. The Recreation Manager (RM) stated that the vendor was contacted and attempted to repair the PASD but was unsuccessful. The RM confirmed that the PASD was malfunctioning since it would become looser with the resident's movements, and this placed the resident's safety at risk. They also stated that the home's policy had not been followed when resident #037's PASD was not applied according to manufacturer's instructions between July 20 and 26, 2016, and when it was not taken out of service when malfunctioning. [s. 8. (1) (b)]

3. The licensee failed to ensure the home's pain management policy was complied with.

A) The home's Interprofessional Clinical Programs policy "Pain Assessment and Symptom Management" (policy number LTC-E-80, last revised November 2015) directed staff to do the following if a resident complained of pain: "A quick pain assessment on the resident will be completed using PQRST and documented to include Provocative (precipitating and palliative factors), Quality (burning, stabbing, dull, throbbing), Region (location, radiating), Severity (mild, annoying to worst case possible), and Timing (what time of day the pain is occurring and when it is worse). "The resident's pain will be measured using a standardized, evidence-informed clinical tool".

According to health records, resident #004 was diagnosed with a terminal illness. During the RQI they complained to the LTC Inspector that they had pain in two areas of their body. Review of health records indicated that they complained of pain on four identified dates over two months in 2016. During interview, RN #110 stated that when a resident's pain was the same, staff did not repeatedly document the same information using the PQRST format, and had not tracked resident #004's pain using the home's pain monitoring. Review of their health record indicated that resident #004's pain had not been assessed/documented according to the home's policy since details had not been included in keeping with the "PQRST" format outlined. The ADOC confirmed this and stated that it was difficult to track the effectiveness of pain management strategies if staff did not assess and document according to the home's policy. (526)

B) The home's policy "Pain Assessment and Symptom Management" (policy number LTC-E-80, last revised November 2015) directed staff to initiate a pain monitoring tool when a new regular pain medication was ordered or there was a dosage increase or decrease of regular pain medication.

Resident #058 fell on an identified date in 2016, and returned from hospital with an injury.

On the following day, the Nurse Practitioner ordered an analgesia every four hours for pain management, and staff were directed to assess the resident's pain control in the morning. Progress notes revealed that the resident complained of pain to the registered staff and told their substitute-decision maker (SDM) that they had throbbing pain. When the SDM brought this forward to registered staff #111, they

assessed the resident who told them they were in pain.

Review of the clinical health record could not identify any pain flow sheets or other pain assessment instruments. Registered staff #114, the ADOC and DOC confirmed that no pain assessment tools could be located. Pain had also not been assessed/documented according to the home's policy since details had not been included in keeping with the "PQRST" format outlined.

C) Interview with the DOC confirmed that it was the expectation of the home that staff complete a pain flow sheet when a resident returns from hospital.

Resident #058 fell on an identified date in 2016, and returned from hospital with an injury. Review of their clinical health record could not identify any pain assessments upon their return from hospital. This was confirmed by the DOC.

D) Interview with the DOC confirmed that it was the expectation of the home to send a resident to the hospital when they were on an anticoagulant and experience an unwitnessed fall or a fall where the resident hit their head.

Resident #058 fell on an identified date in 2016, and returned from hospital with an injury as well as swelling and bruising to multiple areas of their body.

Review of the resident's health record revealed that the resident experienced an unwitnessed fall. Approximately four hours later, the resident was found to be lethargic with slurred speech and decreased level of consciousness, at which time they were sent to the hospital. Interview with the DOC confirmed that resident #058 should have been sent to the hospital immediately after the fall. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A) During interview, resident #009 reported to the LTC Inspector that they were having pain with no relief. Review of their health record indicated that several months prior they sustained an injury that had not healed. According to progress notes they complained to staff at least 61 times over a four month period. They were prescribed regularly scheduled and as needed (PRN) analgesia.

i. Review of progress notes indicated that they told staff a part of their body hurt terribly and especially during a particular type of care. They voiced this to the LTC Inspector as well. Interview with the DOC, and review of the home's investigative notes indicated that staff were aware that the resident had severe pain during care. This information was not put into the resident's plan of care. No pain assessment using a clinically relevant instrument was found in the health record following this incident.

ii. Over a nine-day period in 2016, resident #009's pain was documented, where they described experiencing intense pain on several occasions. The Non-triggered Clinical Resident Assessment Protocol (RAP) for pain indicated that the resident

complained of pain daily and that it was constant. The resident would refuse PRN analgesia, despite these complaints. No pain assessment using a clinically relevant instrument specifically designed for the purpose of assessing pain was found at the time of this quarterly assessment.

During interview, the DOC confirmed that resident #009 was experiencing pain that was not relieved by initial interventions and that a pain assessment using a clinically relevant instrument had not been completed since April 2015. They confirmed that resident #009's pain should have been assessed and the plan of care evaluated and updated so that their pain was managed.

B) According to resident #001's health record, they were administered a regularly scheduled non-narcotic analgesia, and was administered a PRN medication for stomach ache. Review of their progress notes indicated that they complained of pain to multiple areas of their body at least 16 times over a four-month period in 2016. Review of the resident's documented plan of care indicated that there was no plan of care that addressed interventions to prevent or manage resident #001's chronic pain. Progress notes indicated that the resident's Power of Attorney (POA) told the physician that the resident would seek out analgesia; however, they did not want the resident to be administered more than was presently prescribed.

The resident sustained a fall and later had an xray.  The resident complained of pain for eight consecutive days after that.

During interview, the ADOC confirmed that there was no written plan of care to prevent or manage resident #001's chronic pain and there should have been. The ADOC also confirmed that resident #001 continued to have pain that was not relieved by initial interventions, and that their pain had not been assessed using an instrument specifically designed for that purpose. [s. 52. (2)]

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 002**

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**WN #3: 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. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #058 fell which resulted in an injury. The following day the Nurse Practitioner wrote an order for an analgesic every four hours. Review of the resident's clinical health record, including the eMAR and progress notes, revealed that the resident received one dosage after the order was made and did not receive another dosage until approximately 16.5 hours later. Interview with the DOC confirmed the resident did not receive their scheduled analgesic every four hours for their pain as prescribed by the Nurse Practitioner. [s. 131. (2)]

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 003**

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

The following was observed during the course of the RQI:
i. On July 26 and 27, 2016, dietary staff #107 and #108 were observed preparing food without following standardized recipes. Specifically, cauliflower was steamed and served plain without any margarine on it as per the recipe, and the borscht soup had corn starch added at the end of cooking as a thickener, but was not listed on the recipe.

ii. Dietary staff #107 prepared the pureed garden salad without using standardized food production processes i.e. weighing and measuring of ingredients for quality consistency. The salad was put into the processer in bunches while dressing was poured from a large jug into the processor as it pureed. Thickener was added using an ice cream scoop and different amounts were continually added for each batch. The measured amounts according to the package instructions was not followed.

iii. The chicken and rice soup made for lunch on July 26, 2016 and the Borscht soup made for lunch on July 27, 2016, were tasted by the LTC Inspectors. The Inspectors, along with resident #005, found the soups lacked flavour, including seasoning and salt.

iv. On June 26, 2016, during the breakfast meal service on the Post home area, six

place settings were observed set with drinks without the residents present at 0840 hours. By 0900 hours, five of these place settings were still empty. Each setting had a glass of milk which had been sitting out for at least 20 minutes prior to the resident arriving to the dining room.

v. On June 27, 2016, during the lunch meal service on the Trafalgar home area, there was no steam observed coming from the steam table as it did in the other home areas. Dietary staff #109 attempted to turn up the temperature but confirmed the knob did not appear to be functioning properly. The main course of pureed quiche was probed to be at 51.2 degrees Celsius, the mixed vegetables at 55.5 degrees, and the pureed mixed vegetables at 54.7 degrees. The staff member confirmed they still had three trays to plate and serve to residents. Resident #055 indicated that their food was often "warm" rather than "hot".

vi. On July 26, 2016, during a tour of the kitchen, sandwiches were observed in the fridge without any date written on the food items.

Review of the home's Residents' Council meeting minutes, as well as interview with the Council Board Members and residents' #004, #009, and #034 during Stage 1 of the RQI, confirmed that the residents were not happy with the food served in the home. The residents felt that the food lacked flavour and seasoning, and hot food was often served cold. The home's 2015 annual satisfaction survey mirrored these results, having at 53.5 percent (%) overall satisfaction with the food, down from 74.2% in 2014. The category "food tastes ok" scored 46.9% and "temperature of food ok" scored 53.3%. [s. 72. (3) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and (c) a written record was kept of everything required under clauses (a) and (b).

The home's Medication/Treatment Standards policy "Medication Incidents" (policy number LTC-F-220, last reviewed on August 2012) indicated that "near miss" medication incidents were events "that could have resulted in unwanted consequences but did not because, either by chance or through timely intervention, the event did not reach the resident". The policy directed staff to "document medication incidents not involving residents on the 'Medication Incident Report' for further analysis for prevention".

A) During the initial tour of the home, the LTC Inspector observed RPN #102 taking medications out of the medication cart, crushing them and placing them into disposable cups located on their medication cart.

During interview the RPN confirmed that they were pre-pouring medications for resident #037 and resident #048 simultaneously and at least one medication was classed as narcotic. The DOC was asked to attend the medication pass at 1050 hours and confirmed that RPN #102 had not followed the home's policy for medication administration by simultaneously pre-pouring medications for two residents. During interview, the DOC confirmed that this incident increased the likelihood that residents #037 and #048 would receive medications for which they were not prescribed. The DOC confirmed that this could have resulted in harm, injury or death to residents #037 and #048 had they received the wrong medications. This constituted a "near miss" according to the home's policy and legislative requirements. Review of the home's documentation indicated that a "Medication Incident Report" had not been completed for this incident. The DOC confirmed that they had not documented this medication incident, its review or analysis.

B) The home notified the MOHLTC through the Critical Incident System of an incident that occurred in the home on an identified date in 2016, involving a controlled substance that was missing/unaccounted for. Review of the home's investigative notes revealed that while RPN #104 was pre-pouring medications, they allegedly crushed and mixed resident #054's narcotic medication into resident #053's medication cup. Investigative notes revealed that resident #053 refused their medications and did not receive an incorrect medication.

During interview, the DOC confirmed that this incident was a "near miss" event according to the home's policy and legislative requirements. They confirmed that this incident could have resulted in harm, injury or death to residents #053 and #054 had the medication been administered not as prescribed. The DOC confirmed that they had not documented the incident by completing a "Medication Incident Report" according to the home's policy. [s. 135. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in resident #045's plan of care was based on an assessment of the resident and the needs and preferences of the resident.

A) During the RQI, resident #045 told the LTC Inspector their preference for bathing, specifically the frequency, and expressed the importance of this to them. Review of the resident's progress notes revealed that the resident was continually requesting this since their admission last year; however, the home would not accommodate. Interview with the DOC confirmed that the home did not accommodate resident #045's bathing request to meet their needs and preferences.

B) Resident #045's plan of care included documentation stating that the resident could perform part of the bathing activity on their own and for staff to encourage their capabilities to prevent decline.

Resident #045 voiced concern about their bathing to the LTC Inspector, specifically that staff would not always allow them complete certain tasks during their showers even upon their request. Interview with PSW's #105 and #106 confirmed that the resident liked to complete the specific task on their own but this was discouraged as they had an unsteady gait.

The resident's documented plan of care stated the resident like to perform this task on their own but for staff to discourage them from doing so due to safety reasons.

Interview with the DOC confirmed that resident #045 was not being showered to meet the needs and preferences of the resident. [s. 6. (2)]

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #049, #050 and #051 had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Resident #051 was interviewed and identified they wanted to go to bed at a later time than normal during certain times of the year; however, the staff would request for the resident to return to the home area prior to that time. This request to the resident was done to allow the PSW to put the resident to bed before the PSW finished their shift. The resident and families verbalized feeling pressured to return to the home area prior to the identified time; however, would have preferred to stay outside until after that time. The DOC confirmed there was not a plan of care related to desired sleep preferences nor was the desired bedtime supported. [s. 41.]

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident 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) During the RQI the LTC Inspector observed an area of altered skin integrity on resident #002. During interview, the resident stated that they had sustained the injury a number of days earlier. During observation and interview, RN #113 (the home's wound care champion) confirmed that the resident was at risk for skin tears and bruising, and their risk for a skin tear to the altered area was increased.

Review of the resident's health record indicated that this area of altered skin integrity had not been assessed using an instrument specifically designed for that purpose, the plan of care did not include the resident's risk for altered skin integrity, they were at increased risk since they had already sustained an injury and they had not received interventions to mitigate the risks. RN #113 confirmed this during interview on August 3, 2016.

B) Review of health records revealed that resident #004 had areas of altered skin integrity that had not been assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment on six different areas of altered skin integrity between September 2015 and July 2016.

Review of health records indicated that assessments using a clinically relevant instrument had not been completed. The document the home referred to as resident #004's care plan since admission to the home did not include direction for staff in the prevention of altered skin integrity or how to manage their existing skin issues. This was confirmed by the ADOC who stated that staff should have completed assessments when resident #004 exhibited areas of altered skin integrity. [s. 50. (2) (b) (i)]

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were stored in an area or medication cart that was kept secure and locked.

During the initial tour of the home the LTC Inspector observed an unlocked medication cart with no registered staff in view. Residents, housekeeping staff, and family members were observed walking by the unlocked cart during this time. During interview, RPN #102 confirmed that the medication cart was unlocked and that they were not within view of for 15 minutes. The RPN locked the cart and when they went to reopen it, they tried a total of eight keys before they found the key that opened the cart. They stated that they were having trouble finding the key. During interview, the DOC confirmed that the medication cart should have been locked at all times when the RPN was not in view of it in order to ensure that drugs were securely stored. [s. 129. (1) (a)]

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all areas where drugs were stored, were kept locked at all times, when not in use.

During the initial tour of the home the LTC Inspector observed that the door to the medication room was unlocked with no registered staff in view. The LTC Inspector entered the room aand found resident medications stored in the unlocked cupboards within the room. Residents, housekeeping staff and family members were observed walking by the unlocked medication room during that time. RPN #102 walked past the door on three occasions without noticing that the door was unlocked and slightly ajar. When asked, RPN #102 stated that they thought that they had locked the room. During interview, RPN #102 and the DOC confirmed that the medication room where drugs were stored should have been locked at all times when not in use. [s. 130. 1.]

**Issued on this 24 day of August 2016 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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


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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** JESSICA PALADINO (586) - (A1)

**Inspection No. / No de l'inspection :** 2016_511586_0004 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** 015211-16 (A1)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Aug 24, 2016;(A1)

**Licensee / Titulaire de permis :**
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

**LTC Home / Foyer de SLD :**
NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Lesley Harris

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 REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2015_312503_0002, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall do the following :

1. Pain Assessment and Symptom Management

i) Review the "Pain Assessment and Symptom Management" policy and revise as necessary to clarify expectations of staff regarding methods to assess residents' pain, including the use of instruments specifically designed for the purpose of pain assessment when a resident's pain is not relieved by initial interventions according to legislative requirements.
ii) Assess all residents' pain including verbal and non verbal indicators, taking into consideration their level of cognition when assessing, according to the home's policy.
iii) Document and retain assessments including PQRST documentation as directed in the home's policy.

2. Medication Management

The licensee shall do the following:
i) Re-train all registered staff regarding medication administration practices that should include pre-pouring of medications, according to the home's policy and in relation to the definition of a "medication incident" as noted in section 1 of the Regulation as follows:
"medication incident" means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted; ("incident lié à un médicament").

ii) Follow the home's medication administration policy by not pre-pouring medications.

iii) Include incidents where staff are observed pre-pouring medications as "near miss events" in the home's medication management policy and medication programme evaluation.

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm residents #004 and #058 experienced, the scope of multiple incidences, and the Licensee's history of non-compliance (CO) on the January 19, 2015 Resident Quality Inspection with the r.8 (1) (b) related to the home's policies not being followed.
The licensee failed to ensure the home's pain management policy was complied with.

A) The home's Interprofessional Clinical Programs policy "Pain Assessment and Symptom Management" (policy number LTC-E-80, last revised November 2015) directed staff to do the following if a resident complained of pain: "A quick pain assessment on the resident will be completed using PQRST and documented to include Provocative (precipitating and palliative factors), Quality (burning, stabbing, dull, throbbing), Region (location, radiating), Severity (mild, annoying to worst case possible), and Timing (what time of day the pain is occurring and when it is worse). "The resident's pain will be measured using a standardized, evidence-informed clinical tool".

According to health records, resident #004 was diagnosed with a terminal illness. During the RQI they complained to the LTC Inspector that they had pain in two areas of their body. Review of health records indicated that they complained of pain on four identified dates over two months in 2016. During interview, RN #110 stated that when a resident's pain was the same, staff did not repeatedly document the same information using the PQRST format, and had not tracked resident #004's pain using the home's pain monitoring. Review of their health record indicated that resident #004's pain had not been assessed/documented according to the home's policy since details had not been included in keeping with the PQRST format outlined. The ADOC confirmed this and stated that it was difficult to track the effectiveness of pain management strategies if staff did not assess and document according to the home's policy. (526)

B) The home's policy "Pain Assessment and Symptom Management" (policy number LTC-E-80, last revised November 2015) directed staff to initiate a pain monitoring tool when a new regular pain medication was ordered or there was a dosage

increase or decrease of regular pain medication.

Resident #058 fell on an identified date in 2016, and returned from hospital with an injury.

On the following day, the Nurse Practitioner ordered an analgesia every four hours for pain management, and staff were directed to assess the resident's pain control in the morning. Progress notes revealed that the resident complained of pain to the registered staff and told their substitute-decision maker (SDM) that they had throbbing pain. When the SDM brought this forward to registered staff #111, they assessed the resident who confirmed to the staff member that they were in pain.

Review of the clinical health record could not identify any pain flow sheets or other pain assessment instruments. Registered staff #114, the ADOC and DOC confirmed that no pain assessment tools could be located. Pain had also not been assessed/documented according to the home's policy since details had not been included in keeping with the PQRST format outlined.

C) Interview with the DOC confirmed that it was the expectation of the home that staff complete a pain flow sheet when a resident returns from hospital.

Resident #058 fell on an identified date in 2016, and returned from hospital with an injury. Review of their clinical health record could not identify any pain assessments upon their return from hospital. This was confirmed by the DOC. (586)

The licensee failed to ensure that the home's medication policy was complied with.

A) The home's Medication/Treatment Standards policy "Medication Administration" (policy number LTC-F-20, last reviewed January 2016) indicated that "Medications must remain in the original labeled container(s) or package(s) provided by the pharmacy service provider or the Government supply until administered to a resident", and "medications will not be prepared in advance (pre-poured) under any circumstances".

During the initial tour of the home on July 20, 2016, the Long-Term Care Homes (LTC) Inspector observed RPN #102 taking medications out of the medication cart, crushing them and placing them into disposable cups located on their medication cart. During interview the RPN confirmed that they were pre-pouring medications for

resident #037 and resident #048 simultaneously, and at least one medication was classed as narcotic. The RPN stated that they were not aware that pre-pouring medications for more than one resident was not according to the home's policy for medication administration or the College of Nurses Standards. The DOC was asked to attend the medication pass and confirmed that RPN #102 had not followed the home's policy for medication administration by simultaneously pre-pouring medications for two residents. The DOC stated that the medications were discarded and the RPN was instructed regarding the home's policy for medication administration.

B) During review of the home's investigative notes for a CIS Inspection regarding a narcotic that went missing, RPN #104 confirmed that they were "pre-pouring" medications for more than one resident when a narcotic was placed in the wrong resident's medication cup. The DOC confirmed that the RPN should not have been pre-pouring medications as the home's policy directed staff not to prepare medications in advance and to complete the medication pass for one resident before moving on to the next. (526)

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

Nov 30, 2016(A1)

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**Order # /**
**Ordre no :** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall do the following:

1. Re-train staff in the home's Pain Assessment and Symptom Management Programme to include but not limited to the use of best and leading practices in pain assessment and management for residents of all cognitive abilities, in order to determine if a resident is experiencing pain and if their pain is relieved by initial interventions.

2. Assess resident's pain according to leading and best practices and training provided.

3. Document these assessments.

4. Base residents' plans of care on assessments to include pharmacologic and non-pharmacologic strategies to prevent and manage pain.

5. Implement plans of care to prevent and manage pain.

6. When their pain is not relieved by initial interventions, assess all affected residents, including residents #009 and #001, using a clinically appropriate instrument specifically designed for this purpose.

7. Monitor residents' responses to and effectiveness of pain management strategies.

8. Update the plan of care when strategies are ineffective in relieving residents' pain.

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (3), scope

(3) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that residents #001 and #009 experienced, the scope of the widespread incidences, and the Licensee's history of no previous non-compliance in this area.

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

A) During interview, resident #009 reported to the LTC Inspector that they were having pain with no relief. Review of their health record indicated that several months prior they sustained an injury that had not healed. According to progress notes they complained to staff at least 61 times over a four month period. They were prescribed regularly scheduled and as needed (PRN) analgesia.

i. Review of progress notes indicated that they told staff a part of their body hurt terribly and especially during a particular type of care. They voiced this to the LTC Inspector as well. Interview with the DOC, and review of the home's investigative notes indicated that staff were aware that the resident had severe pain during care. This information was not put into the resident's plan of care. No pain assessment using a clinically relevant instrument was found in the health record following this incident.

ii. Over a nine-day period in 2016, resident #009's pain was documented, where they described experiencing intense pain on several occasions. The Non-triggered Clinical Resident Assessment Protocol (RAP) for pain indicated that the resident complained of pain daily and that it was constant. The resident would refuse PRN analgesia, despite these complaints. No pain assessment using a clinically relevant instrument specifically designed for the purpose of assessing pain was found at the time of this quarterly assessment.

During interview, the DOC confirmed that resident #009 was experiencing pain that was not relieved by initial interventions and that a pain assessment using a clinically relevant instrument had not been completed since April 2015. They confirmed that resident #009's pain should have been assessed and the plan of care evaluated and updated so that their pain was managed.

B) According to resident #001's health record, they were administered a regularly

scheduled non-narcotic analgesia, and was administered a PRN medication for stomach ache. Review of their progress notes indicated that they complained of pain to multiple areas of their body at least 16 times over a four-month period in 2016. Review of the resident's documented plan of care indicated that there was no plan of care that addressed interventions to prevent or manage resident #001's chronic pain. Progress notes indicated that the resident's Power of Attorney (POA) told the physician that the resident would seek out analgesia; however, they did not want the resident to be administered more than was presently prescribed.

The resident sustained a fall and later had an xray. The resident complained of pain for eight consecutive days after that.

During interview, the ADOC confirmed that there was no written plan of care to prevent or manage resident #001's chronic pain and there should have been. The ADOC also confirmed that resident #001 continued to have pain that was not relieved by initial interventions, and that their pain had not been assessed using an instrument specifically designed for that purpose. (526)

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

Nov 30, 2016(A1)

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**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. 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).

**Order / Ordre :**

The licensee shall do the following:

1. Review and update as needed, the home's policy regarding medication transcription.

2. Retrain all registered staff in the home regarding transcribing orders in a timely manner and administering pain medication as prescribed according to the home's policy;

3. Transcribe physician and RN in the extended class orders in a timely manner according to the home's policy; and

4. Administer pain medication as prescribed to residents.

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

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #058 experienced, the scope of one isolated incident, and the Licensee's history of non-compliance (VPC) on the October 23, 2013 Critical Incident Inspection with the r. 131 (2) related to medications not being administered as prescribed.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #058 fell which resulted in an injury. The following day the Nurse Practitioner wrote an order for an analgesic every four hours. Review of the resident's clinical health record, including the eMAR and progress notes, revealed that the resident received one dosage after the order was made and did not receive another dosage until approximately 16.5 hours later. Interview with the DOC confirmed the resident did not receive their scheduled analgesic every four hours for their pain as prescribed by the Nurse Practitioner. (586)

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

Nov 30, 2016(A1)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board  and the Director

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

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

**Issued on this 24 day of August 2016 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** JESSICA PALADINO - (A1)

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