Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 27, 2015	2015_198117_0008	O-001647-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573), HUMPHREY JACQUES (599), LINDA HARKINS (126), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 2, 3, 4, 5, 6, 9, 10, 11, 12 and 13, 2015

It is noted that eight (8) Critical Incident Inspections were conducted concurrently

and incorporated in this Resident Quality Inspection Report. The logs for the Critical Incident Inspections are: Log # O-000344-14, # O-000564-14, # O-000623-14, #O-001099-14, #O-001224-14, #O-001414-14, #O-001530-14.

It is also noted that a Follow Up to Orders Inspection was conducted by Inspector Jessica Lapensee, under the following inspection report #2015_346133_0006 Log #O-0011911-14 and that a Complaint Inspection was also conducted concurrently by Inspector Humphrey Jacques under the following Inspection Report #2015_193599_0007 Log # O-001679-15.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Chief Operating Officer, attending physicians, Director of Nursing Operations, Resident Care Managers, Personal Support Supervisors, Director of Support Services, Supervisor of Property Services, RAI Coordinator, Infection Control Lead, Registered Dietitian, several Registered Nurses, several Registered Practical Nurses, the home's Psychogeriatric Nurse, the home's Behavioural Support Ontario (BSO) Champion, several Personal Support Workers, Food and Nutrition Aides, Unit Nursing Clerks, Finance Clerk, Housekeeping Aides, Recreational Therapist, Physiotherapy Aide, Occupational Therapists, Resident Care Liaison, the Chair of the Family (community and veteran) Council, the Chairs of the Community Residents Council and of the Veterans Resident Council, as well as several community and veteran residents.

The inspectors also reviewed several resident health care records, various administrative,nursing and support services policies, Community and Veteran Residents Councils meeting minutes, Family and Friends Council meeting minutes and other documentation within the home. They also observed several meal services and collation passes; resident care and services; resident activities; examined several resident rooms and common areas; resident mobility and care equipment.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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

- **10 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations between Resident # 31 and Resident # 32 by identifying and implementing interventions. [Log # O-001414-14]

On March 9, 2015, Inspector # 126 conducted a critical incident inspection related to physical abuse between Resident # 31 and Resident # 32 which occurred on a specific day in December 2014. It is documented in the critical incident report that Resident # 31 has had 12 incidents of physical aggression towards co-residents since February 2014, which included six incidents directed toward Resident # 32.

The progress notes of Resident # 31 were reviewed for the period from the day of the identified incident in December 2014 to March 10, 2015. It is noted that 3 physical altercations occurred in this period, which included 2 incidents between Resident # 31 and Resident # 32:

On a specified day in December 2014, it is noted in the progress notes that around 1800 hours at the back of the dining room area, Registered Practical Nurse (RPN) S#166 witnessed Resident # 31 holding Resident # 32 by the neck and punching his/her head a couple of times. S#166 asked Resident #31 why that incident happened and Resident # 31 stated “He/She is on my way when I was in the wash room and he/she is bothersome." Resident # 31 also stated that he/she was aware that he/she hit Resident #32 and that he/she would do it again if the resident bothers him/her.

Twenty (20) days later, in December 2014, S#166 documented in the evening progress notes that Resident # 31 was in good spirits throughout the shift but he/she was seen at team 2 common T.V. area commenting on Resident # 32, "If I have the chance to catch you, I will bite you." S# 166 asked Resident # 31 why he/she wanted to hit Resident # 32 and stated “I just don't like him/her, his/her look bothers me”.

Seven (7) days later in December 2014, Registered Nurse (RN) S# 171 documented in the progress notes that Resident # 31 was sitting across the nursing station around 16:40. Resident # 32 was wandering in and out rooms. Resident # 31 heard S#171 redirecting Resident # 32 telling the resident “this is not your room" and Resident # 31 stated: “He/she does not belong anywhere. He/She needs to be kicked in the butt". He/She needs to be locked up on the North side and given something to do". No aggression towards co-residents this shift.

Eight (8) days later, during an identified evening in January 2015, RN S#182 documented in the progress notes that two PSWs reported that they heard yelling at around 1900 and found Resident # 31 and Resident # 32 in another resident room. The PSW entered the room and observed Resident # 31 with his/her hands around Resident # 32 by the back of the neck and was also holding his/her left forearm. S # 166 assessed Resident # 32's neck and forearm no injury noted. Resident # 31 stated that Resident # 32 deserved it and that writer should not give him/her any sympathy.

Eight (8) days later, during an identified morning of January 2015, PSW S# 167 documented in the progress notes that she was stopped in the hallway by the physiotherapy assistant and was advised that Resident # 31 was chasing Resident # 32 down the hall. PSW S #167 went to the back dining room and Resident # 32 was walking back and forth in the dining room. Resident # 31 stated to S# 167 "He/She has been trying to torment me and he/she is a bi**tch, no he/she is worse than that he/she has been bugging me for years I am going to kill him/her". S# 167 turned around to get a cup of coffee for Resident # 32 and at the meantime, Resident # 31 approached Resident # 32 who was standing at his dining room table Resident # 31 was holding Resident # 32 in a choke hold and then pushed his/her neck forward. S# 167 intervened and called out in a loud voice to startle resident and asked kitchen staff to pull emergency bell for assistance. Registered staff notified. S# 167 did 1:1 with Resident # 31.

Interview held with several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Behavioural Support Ontario (BSO) PSW, the Royal Ottawa Psycho Geriatric Team Nurse and the Unit Manager and they are all aware of Resident # 31's responsive behaviors and triggers.

Several interventions are identified for Resident # 31 which includes being followed by the Home's Physician, by the Psycho Geriatric Team (Nurse and Physician) and the BSO PSW. Medications and treatments are reassessed on an ongoing basis and readjusted to minimize the responsive behaviors. Resident # 31 and Resident # 32 are being discussed at the high risk meeting that is being held every two weeks with the multi-disciplinary team. Both Residents have been relocated to have their meals in separate dining rooms. All staff are monitoring the residents to ensure they are not within close proximity of each other.

On March 9, 2015, Inspector # 126 completed a walkabout on the Residents' unit. It was

observed that Resident # 31 has two yellow banners and a stop sign in front of his/her door. It was also observed that Resident # 31's room is located 7 rooms down the same hallway as Resident # 32. In the hallway beside Resident # 32's room, the fire unit doors on the left side corridor were observed to be close and locked. Therefore if Resident # 32 gets out of his/her room, the only way to go out of his/her room, is on the right side which brings Resident #32 to pass in front of Resident # 31's room. Staff explained that these doors are opened and closed during the day and closed during the night. [s. 54. (b)]

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

s. 6. (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 Resident # 31's & Resident # 32's written plan of care set out clear directions to staff and others who provide direct care to the resident. [Log #O-001414-14]

The progress notes were reviewed for the period of a specific day in December 2014 to March 10, 2015. It is noted that 3 physical incidents occurred with a last altercation on an identified day in January 2015 when Resident # 31 held Resident # 32 by the neck in a "choke hold" and was saying "I'm going to break your neck". It is also documented in the

progress notes of that same day in January 2015 that Resident # 31 told the Behavioral Support Ontario (BSO) Personal Support Worker (PSW) that he/she was tormented by Resident #32 and that he/she was going to kill him/her.

Interview held with several staff including, Personal Support Workers, Registered Practical Nurses and Registered Nurses and they all indicated that Resident # 31 & # 32 should be kept apart to prevent occurrence of physical altercation between the two of them. Staff indicated that other residents can also be a trigger for Resident # 31 but it is mainly Resident #32 who is identified as an actual trigger for Resident # 31.

The written plan of care for Resident # 31, dated December 2014 does include that the resident can react to noises of co-residents and can react if they come into his/her space. It does not specify that Resident #32's behaviors are triggers for Resident #31.

The written plan of care for Resident# 32, dated February 2015, does include that the resident has several behaviors, including wandering and making noises, however it does not identify that these that can be triggers for Resident # 31.

The plan of care indicates Resident # 31 & # 32 have some responsive behaviors but does not clearly identify Resident # 32 to be an actual trigger for behaviours in either of the care plans. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan was provided to Resident #03 as specified in the plan. [Log #O-001224-14]

On a specific day in October 2014, Resident #03, who has resided at the home since May 2013, had an episode of choking at supper that resulted in the resident being hospitalized for aspiration pneumonia.

According to the Critical Incident System (CIS) report, it was clearly noted in the dietary kardex that the resident was not to have rice due to a possible choking risk.

Food and Nutrition Aid, Staff Member #160 who was serving the food on that specific day in October 2014 was interviewed. She stated that she was aware that Resident #03's personal sitter restricted intake of rice. She stated that at that meal, she plated chicken, vegetables and mashed potatoes for Resident #03 in a lipped plate, but that the wrong plate, which contained chicken, vegetables and rice was delivered to Resident #03. Staff Member #160 stated that the resident's sitter indicated to her that the plate contained rice

which the resident was not to have, but before the plate was removed and replaced, Resident #03 had begun eating rice and began to choke.

On March 11, 2014, RPN, Staff Member #159 who was working the evening shift and was present when the choking incident occurred stated that Resident #03 was eating rice when he/she choked. Staff Member #159 stated that after the incident she checked the dietary kardex. She stated that she had to look twice, but "to avoid rice" was indicated.

On a specific day in May 2013, in the Registered Dietitian's assessment, she noted that Resident #03 had difficulty swallowing rice, and that his/her diet was general diet, regular texture, no rice. To avoid rice was also noted in the resident's care plan which was initiated 6 days later in June 2013. The care plan directs staff to "See dietary kardex at point of service for details".

The dietary kardex was reviewed. "No Rice – Choking Risk" is indicated, and the start date for this intervention is the identified day in May 2013. On March 13, 2015, Food Service Supervisor, Staff Member #100 stated that a computer program generates the dietary kardex. She confirmed that to avoid rice due to Resident #03's risk of choking had been on the dietary kardex since May 2013, and that this information would have been in the kardex binder when the choking incident occurred. [s. 6. (7)]

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 Resident #31 and #32's written plan of care set out clear directions, as it relates to their responsive behaviours, to staff and others who provide direct care to the residents; as well as to ensure that the care set out in the plan, specifically related to the resident #3's dietary needs, is provided to Resident #03 as specified in the plan, to be implemented voluntarily.

WN #3: 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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. [Log #O-001414-14]

In accordance with O. Regulation 79/10, s.2 (1), "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

In accordance with O. Regulation 79/10, s.2 (1), verbal abuse means any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

The progress notes of Resident # 31, dated on a specific day in January 2015, documented the following: "Writer was stopped in the hallway by physiotherapy assistant and advised that resident (#31) was chasing co-resident (#32) down the hall. Writer went to back dining room and observed (#32) walking back and forth in the dining room. Resident (#31) sitting outside dining area focused on co-resident (#32). Resident (#31) stated to writer that "He/She (#32) has been trying to torment me and he/she is a bi**tch, no he/she is worse than that he/she has been bugging me for years I (#31) am going to kill him/her". Writer turned around to get a cup of coffee for co-resident (#32) and

Resident (#31) approached co-resident (#32) who was standing at his/her dining room table holding (#32) in a choke hold and then pushed his/her neck forward. Writer intervened and called out in a loud voice to startle resident and asked kitchen staff to pull emergency bell for assistance. Registered staff notified. Action: Writer 1:1 with resident."

Writer of incident was identified as being PSW S#167. During an interview held with Inspector # 126, PSW S #167 indicated that Resident # 32 was not resisting the physical aggression and was saying to Resident # 31, "ok, ok, ok". She indicated that after the incident some redness was observed around his/her neck.

It is noted in the progress notes of Resident # 32, that same day in January 2015, for two different assessments conducted by different Registered Practical Nurses on the day and evening shift that "neck around slightly redden'.

On March 12, 2015, during a discussion with Resident Care Manager S#194, the Resident Care Manager indicated to Inspector # 126 that she was notified of the incident when it occurred but did not notify the Director of this incident because the home did not perceive this incident as an incident of abuse. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident.

On March 13, 2015 in Rideau 1 North Room 134, Inspector #573 observed Resident #041's bed system with 2 quarter rails in use. The resident's mattress was short and did not fully fit the deck of the bed frame. Inspector measured the gap to be 8 inches between the end of mattress and foot board of the bed frame (Entrapment Zone 7).

The Health Canada document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" identifies Entrapment Zone 7 as the space between the inside surface of the headboard or foot board and the end of the mattress. No dimensional limit is put forward for Zone 7 although it is identified as potential zone of entrapment.

Inspector #573 reported to the Property Service Supervisor regarding the concerns related to Resident #041's bed system. The Inspector and the property service supervisor proceeded to view the Resident #041's bed system. The Property Service Supervisor identified immediately that the mattress was too small for the bed frame and he agreed with the inspector that it possess safety risk to the resident, further stating that they will address the issue immediately. When Inspector #573 enquired about Bed system assessment, the Property Service Supervisor was not aware of any bed system evaluation.

On March 13, 2015 at Noon the Property Service Supervisor confirmed with the Inspector #573 that the mattress for bed in Room R1N-134 has been changed.

Inspector #573 spoke with the Director of Nursing Operations and the Director of Support Services regarding bed system evaluation for resident's bed system with bed rails in the Home. Both of them were not aware of any bed system evaluation that was completed and could not provide any supporting document regarding home conducting a Bed system evaluation for the residents with the bed rails. [s. 15. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' mobility equipment is kept clean and sanitary.

On March 4 and 6, 2015, Inspectors #117 and #551 observed the following:
• Resident # 10's walker and walker basket are soiled with dried food debris and beverage stains
• Resident #11's Broda chair foot rest is stained with food debris and fluid stains
• Resident #12's wheelchair seat and lap belt are stained and soiled with food debris and art supply debris

On March 10 and 11, 2015, Inspector #117 noted that Residents #10, #11 and #12 mobility equipment was still soiled and stained with food and fluid debris. A review of the residents' monthly equipment cleaning schedule was conducted. No documentation was found for the months of February and March related to the cleaning of Resident #10 walker and Resident #12's wheelchair. No documentation was found related to cleaning of Resident #11's Broda chair since February 21, 2015.

On March 10, 2015, RPN S#136 and PSW S#137 of O1W, PSW S#116 and S#132 of R1S stated to Inspector #117 that it is night time staff who clean residents mobility equipment. They stated that there is a weekly cleaning schedule in the Personal Support Workers Binder in which the night time staff are to document when the residents equipment has been cleaned. They report that if a resident's mobility equipment is soiled between weekly cleaning, this is identified in the unit's daily communication binder so that night staff can clean the equipment sooner than later. This cleaning process was also confirmed by the home's Clinical Care Manager S#161 and RN S#162 of O2E on March 11, and by one of the home's Personal Support Supervisor S#163 on March 12, 2014.

The Personal Support Supervisor S#163 stated that night time staff are to clean residents equipment as per the weekly cleaning schedule and to document when this is done. Should there be a reason why the equipment is not cleaned, there should be documentation to indicate the reason and staff should be rescheduling the cleaning of the equipment.

Resident #10, #11 and #12's mobility equipment were not cleaned. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 30. (1).1 in that the licensee did not ensure that there is a written procedure and protocol to report and locate residents' lost clothing and personal items as required by O. Reg 79/10, 89.1(a)(iv).

As per O.Reg. 79/10, s.30 (1) 1. "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

As per O.Reg. 79/10, s.89 (1), "As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that,(iv) there is a process to report and locate residents' lost clothing and personal items."

On March 4, 2015 during an interview with Resident #025, the resident stated that approximately three months ago, a handmade blue cable knit sweater and a two piece black sweat suit went missing.

The Resident #025 indicated that the missing items were reported to the staff member in the Ottawa Unit and later the resident was informed by a staff member that they could not find the missing clothing.

During an interview with PSW #S174, RPN #S173 and Unit clerk #S175 the Staff members indicated that they were not aware of the missing clothing for Resident #025. When inspector inquired about the home's process for reporting and locating residents lost clothing, each staff member in the same Ottawa unit mentioned different procedures for locating missing or lost resident clothes.

On March 10, 2015 Inspector # 573 spoke with Ottawa unit Manager of Resident Care #S161 who stated that they do not have a written process for reporting and locating residents missing or lost clothing.

On March 10, 2015 Director of Support Services provided the home's policy regarding lost and found. Upon reviewing the policy for lost and found, it identifies about the retention of lost clothing in the laundry department but it did not address any process or procedure for reporting and locating residents missing or lost clothing.

On March 12, 2015 Inspector #573 spoke with the Director of Support Services who stated that the home do not have a written procedure and protocol to report and locate residents' missing or lost clothing. [s. 30. (1) 1.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

The President of Veterans Residents Council (VRC) indicated during an interview with Inspector #573 that the Council does not receive any written response within 10 days from the Licensee regarding any advice or concerns made by the VRC. The President of the Veterans Residents' Council further indicated that the concerns were addressed in the next or subsequent Council meeting.

Inspector #573 reviewed the Veterans Residents Council meeting minutes between September 2014 and January 2015. The Veterans Residents' Council meeting minutes of January 13, 2015 identified concerns regarding recruiting volunteer bus drivers without any input or consultation with the Veterans Residents Council and concerns from the council members that soups are watery and unappetizing were forwarded to management. There is no written evidence to support that a written response from the licensee regarding the identified concerns was communicated within 10 days to the Veterans Residents' Council.

On March 12, 2015 The Chief Operating Officer reported to the Inspector #573 that the response to any concerns and recommendations from the Veterans Resident Council is documented and presented to the Council in the subsequent meeting and further she stated that a written response is not always provided within 10 days to the Veterans Residents Council. [s. 57. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, a review, subject to compliance with subsection 71(6), of meal and snack times by the Residents Council.

On March 3, 2015 in two separate interviews, Inspector #573 spoke with the Veterans and Community Residents Council Presidents. The Veterans Resident Council president stated that the Council was never consulted regarding the review of dining and snack services time and Community Residents Council President stated to the inspector that she could not recall the Resident Council reviewing the home's meal and snack times.

Inspector #573 reviewed both the Veterans and Community Residents Council meeting minutes between January 2014 and January 2015. The inspector noted that there was no documentation in the minutes regarding any review of the meal and snack times with the Residents' Council. Further upon reviewing the Veterans Residents' Council meeting minutes for December 9, 2014 it identifies few residents concern in Rideau Unit regarding the timing of the breakfast.

On March 12, 2015 the Director of Support Services reported to the Inspector #573 that the Home has reviewed the meal and snack times with both the Residents' Council Meetings but unable to provide any supporting document or evidence regarding the review of the meal and snack times with both the Residents' Council. [s. 73. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to hospital and that result in a significant change in the resident's health status. [Log #O-001224-14]

Resident #03 had a choking episode at supper on a specified day in October 2014 after which he/she was sent to the hospital through emergency. A progress note entry written on the day of the incident in October 2014 indicates that the resident will be admitted tonight to the hospital with a diagnosis of an infection.

Resident #03 returned to the home two (2) days later in October 2014. The resident was ordered to continue an antibiotic treatment (a five day course was started in hospital). Resident #03 was assessed by a Speech Language Pathologist (SLP) in hospital and was assessed as being at risk with the intake of specific foods. New food restrictions as per the SLP's recommendation were implemented including that Resident #03 was not to consume raw fruits or vegetables and dry foods that separate or crumble including dry, hard meat, rice and granola.

The Director was notified of the incident through a Critical Incident Report three (3) days after Resident #03 was admitted to hospital, one day after his/her return to the home. The Director was not notified of the incident within one business day as per legislated timelines. [s. 107. (3) 4.]

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

Specifically failed to comply with the following:

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

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #8's use, application, monitoring, release and removal of a lap belt restraint is documented as well as that the resident's condition is reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstance.

Resident # 8 has dementia and mobilizes with the aid of a self-propelled wheelchair. The resident is identified as being at high risk for falls due to agitation and restlessness associated with his/her dementia. Between a specific day in October 2014 and a specific day in February 2015, Resident #8 had 15 falls from his/her wheelchair, with no injuries. Health care records indicate that a lap belt was applied to the resident's wheelchair in July 2014 by the home's Occupational Therapist (OT). The lap belt was being used as a safety device to help with the resident's positioning and to prevent the resident from sliding in his/her wheelchair. Documentation indicates that Resident #8 could undo the lap belt and that this was not a restraint. Unit nursing staff RN S#115, RPN S#153 and PSW S#116 stated to Inspector #117 on March 10, 2015 that at that time, the resident was able to undo the lap belt with no difficulties at that time.

In October 2014, documentation indicates that the resident was presenting with increased periods of agitation and restlessness which escalated throughout November and December 2014. This resulted in Resident #8 undoing his/her wheelchair lap belt, attempting to get up and out of his/her wheelchair, and falling in front or beside his/her wheelchair. In December 2014, the resident is noted to have fallen 5 times within a period of 12 days and then once more 10 days later, in December 2014.

During this same time period, the resident's attending physician and nursing staff with the assistance of psychogeriatric outreach services and the home's OT reviewed Resident #8's responsive behaviours and fall prevention interventions. This included a review of the resident's medication, environmental stimuli and his/her wheelchair. Between a specified day in October and another specific day in December 2014, the resident's wheelchair seating, positioning and lap belt were reassessed by the OT on three separate occasions. On a specific day in December 2014, a new lap belt with a frog clip front closure was applied to the wheelchair. OT assessments indicate that at that time Resident #8 was not able to consistently undo the lap belt and that the lap belt was deemed to be a restraint. On that same day in December 2014, medical orders and consent from the resident's Power of Attorney, for the use and application of the lap belt

restraint were received.

Inspector #117 observed Resident #8 on March 5, 9 and 10, 2015. The resident was noted to have his/her lap belt in place as per the plan of care. Unit RPNs S#153, S#154 and PSW S#116 indicated that the resident's lap belt is consistently being applied when the resident is up in his/her wheelchair. They also indicated that the lap belt was not a restraint as the resident could undo it on occasions. On March 10, the resident was approached several times by the Inspector as well as the unit RPN S#153, PSW S#116 and PTA S#197 to see if the resident could undo the lap belt. The resident was not to be able to undo the lap belt.

On March 10, 2015, the unit RN S#115, confirmed that the lap belt was indeed a restraint as the resident could not consistently undo the lap belt on command. She indicated that the use of the restraint was added to Resident #8's plan of care on a specified day in December 2014, and that this was communicated to unit nursing and PSW staff.

Upon further review with the unit RN S#115 of the resident's health care record, it was noted that there was no information related to the daily application, monitoring, repositioning and removal of the resident's lap belt restraint. Nor was there any assessment of the resident's response to the use and application of the lap belt residents. Furthermore, there was no documentation indicating that the resident's condition had been reassessed and the effectiveness of the restraining evaluated a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

The RN S#115, RPN S#153 and PSW S#116 confirmed that since the application of Resident #8's wheelchair lap belt as a restraint, on a specified day in December 2014, its use, application, monitoring, release and removal was not documented. As well, the assessment of the resident's condition and effective use of the lap belt was not done at least every 8 hours. [s. 110. (2) 6.]

Issued on this 27th day of March, 2015

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

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573), HUMPHREY JACQUES (599), LINDA HARKINS (126), MEGAN MACPHAIL (551)
Inspection No. / No de l'inspection :	2015_198117_0008
Log No. / Registre no:	O-001647-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 27, 2015
Licensee / Titulaire de permis :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 Russell Road, OTTAWA, ON, K1G-5Z6
LTC Home / Foyer de SLD :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Akos Hoffer

To THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

In order to achieve compliance with O. Reg. 79/10, s.54. (a), the licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between Resident # 31 and Resident # 32 by:

Advising all direct care staff at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

Monitoring changes in medications and contacting physicians if needed Documenting incident as per the home's requirements and ensuring care plan is providing clear direction to staff .

Reporting to the Director if there is an incident of alleged abuse as per legislative requirements.

Identifying potential triggers, factors, based on an interdisciplinary assessment and implementing effective interventions to ensure Resident # 32 is in a safe environment.

The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79/10, s.54. (a).

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations between Resident # 31 and Resident # 32 by identifying and implementing interventions. [Log # O-001414-14]

On March 9, 2015, Inspector # 126 conducted a critical incident inspection related to physical abuse between Resident # 31 and Resident # 32 which occurred on a specific day in December 2014. It is documented in the critical incident report that Resident # 31 has had 12 incidents of physical aggression towards co-residents since February 2014, which included six incidents directed toward Resident # 32.

The progress notes of Resident # 31 were reviewed for the period from the day of the identified incident in December 2014 to March 10, 2015. It is noted that 3 physical altercations occurred in this period, which included 2 incidents between Resident # 31 and Resident # 32:

On a specified day in December 2014, it is noted in the progress notes that around 1800 hours at the back of the dining room area, Registered Practical Nurse (RPN) S#166 witnessed Resident # 31 holding Resident # 32 by the neck and punching his/her head a couple of times. S#166 asked Resident #31 why that incident happened and Resident # 31 stated "He/She is on my way when I was in the wash room and he/she is bothersome." Resident # 31 also stated that he/she was aware that he/she hit Resident #32 and that he/she would do it again if the resident bothers him/her.

Twenty (20) days later, in December 2014, S#166 documented in the evening progress notes that Resident # 31 was in good spirits throughout the shift but he/she was seen at team 2 common T.V. area commenting on Resident # 32, "If I have the chance to catch you, I will bite you." S# 166 asked Resident # 31 why he/she wanted to hit Resident # 32 and stated "I just don't like him/her, his/her look bothers me".

Seven (7) days later in December 2014, Registered Nurse (RN) S# 171 documented in the progress notes that Resident # 31 was sitting across the nursing station around 16:40. Resident # 32 was wandering in and out rooms. Resident # 31 heard S#171 redirecting Resident # 32 telling the resident "this is not your room" and Resident # 31 stated: "He/she does not belong anywhere. He/She needs to be kicked in the butt". He/She needs to be locked up on the North side and given something to do". No aggression towards co-residents this shift.

Eight (8) days later, during an identified evening in January 2015, RN S#182 documented in the progress notes that two PSWs reported that they heard yelling at around 1900 and found Resident # 31 and Resident # 32 in another resident room. The PSW entered the room and observed Resident # 31 with his/her hands around Resident # 32 by the back of the neck and was also holding his/her left forearm. S # 166 assessed Resident # 32's neck and forearm no injury noted. Resident # 31 stated that Resident # 32 deserved it and that writer should not give him/her any sympathy.

Eight (8) days later, during an identified morning of January 2015, PSW S# 167 documented in the progress notes that she was stopped in the hallway by the physiotherapy assistant and was advised that Resident # 31 was chasing Resident # 32 down the hall. PSW S #167 went to the back dining room and

Resident # 32 was walking back and forth in the dining room. Resident # 31 stated to S# 167 "He/She has been trying to torment me and he/she is a bi**tch, no he/she is worse than that he/she has been bugging me for years I am going to kill him/her". S# 167 turned around to get a cup of coffee for Resident # 32 and at the meantime, Resident # 31 approached Resident # 32 who was standing at his dining room table Resident # 31 was holding Resident # 32 in a choke hold and then pushed his/her neck forward. S# 167 intervened and called out in a loud voice to startle resident and asked kitchen staff to pull emergency bell for assistance. Registered staff notified. S# 167 did 1:1 with Resident # 31.

Interview held with several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Behavioural Support Ontario (BSO) PSW, the Royal Ottawa Psycho Geriatric Team Nurse and the Unit Manager and they are all aware of Resident # 31's responsive behaviors and triggers.

Several interventions are identified for Resident # 31 which includes being followed by the Home's Physician, by the Psycho Geriatric Team (Nurse and Physician) and the BSO PSW. Medications and treatments are reassessed on an ongoing basis and readjusted to minimize the responsive behaviors. Resident # 31 and Resident # 32 are being discussed at the high risk meeting that is being held every two weeks with the multi-disciplinary team. Both Residents have been relocated to have their meals in separate dining rooms. All staff are monitoring the residents to ensure they are not within close proximity of each other.

On March 9, 2015, Inspector # 126 completed a walkabout on the Residents' unit. It was observed that Resident # 31 has two yellow banners and a stop sign in front of his/her door. It was also observed that Resident # 31's room is located 7 rooms down the same hallway as Resident # 32. In the hallway beside Resident # 32's room, the fire unit doors on the left side corridor were observed to be close and locked. Therefore if Resident # 32 gets out of his/her room, the only way to go out of his/her room, is on the right side which brings Resident #32 to pass in front of Resident # 31's room. Staff explained that these doors are opened and closed during the day and closed during the night.
(126)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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