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
Mar 03, 2017;	2016_273638_0020 (A1)	020539-16, 020541-16, 020575-16, 020576-16, 020577-16, 020578-16, 020579-16, 020580-16	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due dates extended

Issued on this 3 day of March 2017 (A1)

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

Original report signed by the inspector.

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

CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 12-14, 17-21 and 24-25, 2016.

The Follow-Up inspection consisted of the following:

-Order #001 of report #2016_264609_0007, which was related to staffing levels within the home not meeting the assessed needs of the residents.

-Order #002 of report #2016_264609_0007, which was related to incomplete bed rail assessments and evaluations within the home.

-Order #003 of report #2016_264609_0007, which was related to the home's process related to skin and wound identification, interventions and implementation to address altered skin integrity of residents in the home.

-Order #004 of report #2016_264609_0007, which was related to staff education regarding the process for residents demonstrating responsive behaviours.

-Order #005 of report #2016_264609_0007, which was related to dining services, including; assistance, positioning and communication for meals.

-Order #006 of report #2016_264609_0007, which was related to care plans not being current and up to date regarding resident needs and preferences.

-Order #007 of report #2016_264609_0007, which was related to the need to re-train staff regarding the complaint process.

-Order #008 of report #2016_264609_0007, which was related to the home's failure to ensure that the plan of care was provided to the resident as specified in the plan.

A Complaint inspection #2016_273638_0019, was also conducted concurrently with this Follow-Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed personnel files, licensee policies, procedures and programs and relevant health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Medication

Minimizing of Restraining

Pain

Personal Support Services

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

- **7 WN(s)**
- **1 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	CO #002	2015_320612_0020	638
O.Reg 79/10 s. 54.	CO #004	2016_264609_0007	638
LTCHA, 2007 s. 8. (1)	CO #001	2015_320612_0020	638
LTCHA, 2007 s. 8. (1)	CO #001	2016_264609_0007	638

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. 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 were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident.

During inspection #2016_264609_0007, compliance order (CO) #002 was served on June 6, 2016, related to bed rail systems, which ordered the licensee to;
"a) Develop and implement an assessment tool to ensure that every resident that uses bed rails is assessed and their 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.
b) Maintain a record of every resident specific assessment completed for the safe use of bed rails and if any assessment failed when and what the home did to address the safety risk.
c) Provide retraining to all staff who provide direct care to residents on the home's policies and procedures related to bed rails and their responsibilities to ensure bed rail safety.
d) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, b and d", section "c", where the licensee was ordered to ensure that all staff of the home were to have completed re-training related to the home’s bed rails policies and procedures was not completed.

Inspector #638 reviewed the home’s staff training records as of October 12, 2016, related to the home’s bed rails program which indicated that 21 out of 103 staff or 20 per cent of the home’s staff did not complete the required re-training.

In an interview with the Inspector, the ADOC stated that all staff should have completed the required re-training as specified within the order report submitted to the home on June 6, 2016. [s. 15. (1) (a)]

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident at risk of altered skin integrity had received a skin assessment by a member of the registered nursing staff, upon the return of the resident from hospital.

During inspection #2016_264609_0007, CO #003 was served on June 6, 2016, whereby, the licensee was ordered to identify all residents who had altered skin integrity and ensure interventions were implemented to address the skin integrity issues. The licensee was also ordered to provide retraining to nursing and personal support staff related to the Skin and Wound Care program.

A complaint was submitted to the Director, which indicated that resident #002 had been hospitalized due to health complications.

The Inspector reviewed resident #002's health care record during the time period surrounding their hospitalization, which failed to identify any skin assessments completed upon their return to the home from the hospital.

In an interview with the Inspector, RN #115 stated that upon a resident's return to the home from hospital, a head to toe skin assessment should have been completed.

The Inspector reviewed the home's policy titled, "Re-Admission From Hospital" last reviewed June 6, 2016, which indicated that it was the duty of the home's registered staff to ensure that a head to toe skin assessment was completed upon re-entry to the home.

The Inspector conducted a follow up record review with the DOC. The DOC was unable to identify any skin assessments which were completed upon resident #002's return from the hospital. The DOC stated that the required head to toe skin assessment would have been documented within the assessments tab in Point Click Care (PCC) and it was not. [s. 50. (2) (a) (ii)]

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

A complaint was submitted to the Director, related to new instances of altered skin

integrity of an unknown origin that resident #028 had sustained.

Inspector #638 reviewed the progress notes of resident #028, which indicated that the resident had exhibited a new instance of altered skin integrity, and that it was brought forward to the RN by family. In a review of the completed assessments on resident #028, the Inspector failed to identify any formal assessment that had been completed for the resident when the new area of altered skin integrity was discovered.

In an interview with the Inspector, RPN #109 stated that whenever a resident developed a new skin integrity concern, a skin alert assessment would have been completed in order to monitor the status of the wound.

In an interview with the Inspector, the DOC stated that there was no formal wound assessment completed for resident #028. The DOC then stated that there should have been an assessment completed for any new incident of altered skin integrity. [s. 50. (2) (b) (i)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home which included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to have been taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

During inspection #2016_264609_0007, CO #007 was served on June 6, 2016, whereby, all staff of the home were required to have completed re-training related to the home's complaint policy. This education was to have been completed by July 31, 2016.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to the home's complaint program, which indicated that 45 of 109 staff or 29 per cent of the home's staff had not completed the required re-training.

In an interview with the Inspector, the ADOC stated that all staff should have completed the required re-training as ordered during inspection #2016_264609_0007.

In an interview, the Administrator stated that all staff should have completed the required re-training on the complaint policy and that 45 active staff members had not completed the training prior to the follow-up inspection. [s. 101. (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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

During inspection #2016_264609_0007, CO #008 was served to the licensee on June 6, 2016, related to plan of care, which ordered the licensee to;
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care.
b) Perform an assessment of all residents to identify which residents require special treatments including but not limited to oxygen therapy, bed alarms and hip protectors, to ensure that the plans of care for the identified residents include all interventions to manage their special treatments and that it is up to date.
c) Perform an assessment of all residents to identify which residents of the home are experiencing pain, to ensure that the plans of care for the identified residents include all interventions to manage their pain and that it is up to date.
d) Perform an assessment of all residents to identify which residents of the home have resistance to care, wandering and any other responsive behaviours, to

ensure that the plans of care for the identified residents include all interventions to manage their behaviours and that it is up to date.
e) Perform an assessment of every resident of the home to identify which residents require incontinence care, to ensure that the plans of care for the identified residents include all interventions to manage their incontinence and that it is up to date.
f) Perform an assessment of every resident of the home to identify which residents require oral hygiene oral hygiene assistance, to ensure that the plans of care for the identified residents include all interventions to manage their oral hygiene needs and that it is up to date.
g) Ensure that the oral hygiene required by resident #001 is provided to the resident as specified in the resident's plan of care, regardless of the staffing levels in the home.
h) Perform an assessment of every resident of the home to identify which residents required specific instruction to be followed by staff related to resident positioning in chairs and beds, to ensure that the plans of care for the identified residents include all interventions related to positioning and that it is up to date.
i) Ensure that the two bed baths per day identified in the plan of care for resident #022 that are required to maintain the resident's skin integrity are provided regardless of the staffing levels of the home.
j) Provide retraining to all staff involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care. The retraining must also include focused education to direct care staff involved in the care of any of the residents identified in the required assessments that resulted in changes to the plans of care.
k) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, c, e, f, h, i and k", sections "b, d, g and j" were not completed at the time of inspection.

During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016, the licensee was ordered to have performed an assessment of all residents to identify which residents of the home required special treatments, to ensure that the plans of care for the identified residents included all interventions to manage their special treatments and that it was up to date.

Inspector #638 reviewed three residents (#025, #026 and #027) identified by the personal support staff, who required special treatments and reviewed their care plans to ensure they were current to the resident's assessed needs and preferences.

a) Observations made on October 12, 2016, indicated resident #027 had a specific device to be used while the resident was in their wheelchair.

Inspector #638 conducted a record review of resident #027's care plan, which indicated that the resident was to have their specific device at all times while sitting in their wheelchair as an intervention.

In an interview with the Inspector, RPN #103 stated that resident #027 required this device on at all times while sitting in their wheelchair.

The home's policy titled "Care Planning", last reviewed November 19, 2015, indicated that staff were expected to ensure that care was provided to the resident as set out within the plan.

In an interview with the Inspector, the DOC stated that the care should have been provided as per the plan of care.

b) Observations made of resident #025 during their dining service on October 12, 2016, showed the resident #025 had a transferring device under them while seated in their wheelchair.

Inspector #638 reviewed the care plan for resident #025 which indicated that the transferring device was to be removed and could not remain under the resident as an intervention to their impaired skin integrity focus.

The Inspector conducted an interview with PSW #102 who stated that the transferring device must be removed whenever the resident was seated in their wheelchair as specified within their care plan.

In an interview with the Inspector, PSW #107 stated that the resident had specific responsive behaviours and the transferring device was left under the resident during those periods. The Inspector reviewed the care plan for resident #025 with PSW #107 which gave no indication that the transferring device was to be left under the resident at any time. PSW #107 then stated that the transferring device

should have been removed as indicated in the care plan. [s. 6. (7)]

2. During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016, the licensee was ordered to ensure that resident #001 received their oral hygiene requirements as specified in the resident's plan of care, regardless of the staffing levels in the home.

Inspector #638 conducted a record review of resident #001's care plan which indicated that the resident's oral hygiene requirements directed staff to perform specific interventions each evening for the night as well as provide specific interventions after each meal.

A review of the oral hygiene records for resident #001 over a two month period, indicated that the oral hygiene care was only signed for in the mornings and evenings, with the exception of four days where the oral hygiene record was only signed once for the day.

In an interview with the Inspector, PSW #100 stated that resident #001 did not always eat large amounts of their meal and as a result oral hygiene was not done after each meal. In a concurrent interview with PSW #100 it was determined that the plan of care stated that the resident required oral hygiene performed after each meal as per the physician's request. The PSW stated that the care should have been provided as per the plan of care. [s. 6. (7)]

3. A complaint was submitted to the Director regarding an incident of resident #002, which resulted in actual harm, requiring the resident to be sent to the hospital where they passed away. The complaint letter indicated that resident #002's specific interventions were not implemented at the time of the incident.

Inspector #638 conducted a review of the care plan implemented for resident #002 at the time of the incident, it was determined that the resident was required to be wearing a specific intervention as an intervention related to their risk for falls. The Inspector reviewed the progress notes for resident #002 which indicated the resident had suffered an injury. The progress notes indicated that it was not clear if the resident's specific intervention was implemented prior to the incident. In a review of the application record for resident #002, it was determined that the intervention was not implemented at the time of their incident.

In an interview with PSW #118, it was verified that the intervention had not been

implemented as specified within the plan of care at the time of the incident. PSW #118 stated that the resident had not been checked at the beginning of their shift in order to determine if the specific intervention had been implemented.

In an interview with the Inspector, the DOC stated that resident #002 did not have their intervention implemented at the time of the incident. The DOC stated that the care set out in the plan was not provided to the resident as specified in their plan to ensure that the resident's assessed needs were met. [s. 6. (7)]

4. During inspection #2016_264609_0007, CO #008 was served on June 6, 2016, the licensee was ordered to re-train all staff involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to the home's care plan policies and procedures which indicated that 19 of 103 staff or 18 per cent of the home's staff had not completed the required re-training related to the home's care planning program. This education was to have been completed by July 31, 2016.

In an interview, the ADOC stated that all staff were to have completed the re-training regarding the home's care planning program and that 19 active staff members had not completed the training prior to the follow up inspection. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016, ordering the home under section "i)" to ensure that resident #022 received their resident specific care, regardless of staffing levels in the home. The Inspector determined at the time of inspection that the home complied their requirements under Order #008, section "i)" as staff were able to confirm that the required care was provided, however, the Inspector was unable to locate documentation related to the care provided.

Inspector #638 reviewed resident #022's care audit report which indicated that over a period of 10 days in September 2016, the resident's documentation report was not signed for in entirety on eight out of the ten days or considered incomplete 80 per cent of the time.

In a concurrent review of the Point of Care (POC) records, the Inspector noted that on one of the days and one of the afternoon shifts in September 2016, no care for resident #022 was documented.

Inspector #638 reviewed the POC documentation of resident #030 during one day shift in October 2016, which indicated that no documentation had occurred for the resident under the resident care areas; nutrition, hydration, skin integrity, behaviours and activity.

The Inspector expanded their sample size regarding documentation within POC which indicated that 51 out of 127 or 40 per cent of the residents on the selected day in October 2016, day shift were missing their documentation related to the required care interventions as per their plans of care.

In an interview with the Inspector, PSW #119 stated that all care should be documented to ensure that staff were aware of what care was provided or missed in order to ensure that the resident received all care required as per their assessed needs.

In an interview, the DOC stated that all care provided, refused or missed to the resident should be documented in order to determine if care was provided as set out in the plan of care and to determined whether the resident's assessed needs were being met. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During inspection #2016_264609_0007, CO #006 was served on June 6, 2016. The licensee was ordered to ensure that every resident was to have been reassessed and their plans of care reviewed and revised whenever the resident's care needs changed. The licensee was also ordered to have developed and implemented a monitoring system to ensure that when the needs of the residents change, that their care plans would reflect the changes.

a) Inspector #638 reviewed the care plan for resident #026, which indicated that the resident required interventions related to their area of altered skin integrity.

The Inspector reviewed the progress notes and assessment records of resident #026 which failed to have documented any assessments or notes indicating that the resident had any skin integrity issues.

A review of the physician medical directives indicated that these interventions had been discontinued on a specific day in September 2016.

In an interview with RPN #109, it was determined that resident #026 did not have any areas of altered skin integrity at the time and that the care plan should have been updated when the treatment was discontinued as the wound had been resolved.

The Inspector interviewed the Administrator and DOC, who stated that the plan of care should have been reviewed and revised when the care needs of a resident change.

b) Inspector #638 conducted a record review of resident #026's care plan, which indicated that staff would refer to the electronic Medication Administration Records (eMAR) for pharmacological analgesics related to the resident's risk for pain focus within the care plan.

In an interview with the Inspector, RPN #113 stated that resident #026 did not receive any pharmacological analgesics and had no interventions related to pain as the resident did not have a significant history of pain.

The Inspector and ADOC reviewed resident #026's physician ordered medications, which indicated that the resident had no ordered pharmacological analgesics. The ADOC verified that the resident did not have any ordered analgesics and the care plan required to be updated.

c) During inspection #2016_264609_0007, a compliance order was served on June 6, 2016, whereby the licensee was ordered to develop and implement a monitoring system in order to ensure that when a resident's care needs changed that they were reassessed and their plan of care revised, so that staff were aware of the changes and provided care to the resident as specified, with a compliance date of July 31, 2016, to have the system implemented.

In an interview with the Inspector, the DOC stated that the home was in the process of developing a monitoring tool to assess the needs of the residents and to

ensure that their care plans were kept up to date with relevant information. The Administrator stated that the monitoring system had not been finalized and had not been implemented in the home. [s. 6. (10)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004,005

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
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).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During inspection #2016_264609_0007, CO #005 was served on June 6, 2016, related to dining and snack services, which ordered the licensee to;
"a) Ensure that the daily and weekly menus are communicated to residents and that this information is properly communicated to residents regardless of staffing levels within the home.
b) Perform an assessment of every resident of the home that utilizes a tilt chair to ensure that the plan of care gives clear direction to staff regarding the positioning of the residents during and after meals.
c) Ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs and that the resident's plan of care gives clear direction to staff as to how to serve each resident.
d) Ensure that all eating aids, assistive devices, and staff assistance are provided to every resident to safely eat and drink as comfortably and independently as possible, focusing on how staff are to provide encouragement to feed with residents.
e) Provide retraining to all staff involved in the direct care of residents on the home's policies and procedures related to proper techniques for assisting residents with feeding, that staff do not feed more than two residents at a time, as well as the roles and responsibilities of each staff member to ensure compliance with the cited policies and procedures.
f) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, b, c and f", sections "d and e" had not been complied at the time of the inspection.

a) During inspection #2016_264609_0007, a CO #005 was served on June 6, 2016. The licensee was ordered to ensure that all eating aids and resident specific assistance needs including the positioning of residents, was provided to the residents as required.

During dining observations by Inspector #638 on October 12, 2016, the Inspector noted that resident #025 and #027 both had been positioned in a particular

manner, while eating their lunches.

The Inspector reviewed the care plan for resident #027, which gave no indication that they were to be positioned in the manner that they were during the observations. Resident #025's care plan indicated; under the "Eating & Nutritional Needs" focus that the resident was to be seated in a specific manner to minimize their risk of choking or aspiration, which was opposite to how they were actually positioned during their meal.

In an interview with the Inspector, RPN #106 stated that residents were positioned for meals as specified within their plans of care in order to reduce any potential safety risk to the residents. RPN #106 reviewed the care plan for resident #027 and stated that there was no indication that the resident was to have been positioned in the manner that they were and they should not have been positioned in that manner.

During an interview with the Inspector, PSW #101 stated that resident #027 required to be positioned in a specific position during meal times to ensure that they swallow their food effectively and minimized their risk of choking.

The Inspector interviewed the DOC, who said that each resident had been assessed to determine their needs and that their specific direction was laid out within the plan of care. In a concurrent interview with the DOC it was determined that proper techniques should have been used to assist residents with their meals, including safe positioning to ensure that the resident was assisted with eating in a manner according to their assessed needs.

b) During inspection #2016_264609_0007, a CO #005 was served on June 6, 2016, where all staff of the home were ordered to have completed re-training related to the home’s policies and procedures related to proper techniques for assisting residents with feeding, that staff would not feed more than two residents at a time, as well as the roles and responsibilities of each staff member, this education had a compliance date of July 31, 2016.

Inspector #638 reviewed the home’s staff training records as of October 12, 2016, related to proper feeding techniques to assist residents with eating, which indicated that 20 of the 108 active staff or 18 per cent had not completed the required re-training in the allotted time.

In an interview with the Inspector, the DOC confirmed that the 20 staff members who had not completed the re-training were actively working within the home and that all staff should have completed the education on proper techniques to assist residents with eating by the compliance date. [s. 73. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who had demonstrated responsive behaviours, the behavioural triggers for the resident were identified, where possible and strategies were developed and implemented to respond the

these behaviours, where possible.

During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016. The licensee was ordered to "Perform an assessment of all residents to identify which residents of the home have resistance to care, wandering and any other responsive behaviours, to ensure that the plans of care for the identified residents include all interventions to manage their behaviours and that it is up to date".

Inspector #638 reviewed three residents (#001, #025 and #029) identified by the personal support staff, who had demonstrated episodes of responsive behaviours and reviewed their care plans for interventions to manage responsive behaviours.

a) A record review of the Minimum Data Set (MDS) assessment completed in October 2016, for resident #025 indicated that the resident had displayed multiple episodes of responsive behaviours, one to three times within the seven day assessment period.

In an interview with the Inspector, PSW #107 stated that resident #025 frequently demonstrated responsive behaviours towards staff during care giving periods. The Inspector conducted a review of the care plan with PSW #107,who was unable to locate within the care plan of resident #025, a focus, goal or interventions that the resident had any responsive behaviours.

The home's policy titled "Responsive Behaviours" last reviewed June 6, 2016, indicated that for each resident demonstrating responsive behaviours, their plan of care must at minimum address: behavioural triggers, strategies to respond to these behaviours, interventions and strategies for eliminating reversible causes, where applicable.

In an interview with the Inspector, the DOC stated that the care plan should have been updated to identify the behavioural triggers for resident #025. The DOC also stated that any resident who had demonstrated responsive behaviours should have identified triggers and interventions within their plans of care.

b) During inspection #2016_264609_0007, it was identified that resident #001 had increased responsive behaviours. Resident #001 had displayed increased responsive behaviours on 24 separate days during a three month period, and that their plan of care provided no indication of any responsive behaviours the resident

had exhibited.

Inspector #638 conducted a review of resident #001's progress notes, which indicated that the resident continued to have frequent episodes of responsive behaviours towards staff, three occasions of these behaviours occurred during a one month period. In a review of resident #001's MDS assessment completed, indicated that the resident had displayed one to three episodes of responsive behaviours during the seven day assessment period. A review of resident #001's current care plan failed to identify a focus, goal or interventions for the responsive behaviours the resident had exhibited or been assessed as having.

In an interview with the Inspector, PSW #100 stated that resident #001 had displayed an increase in responsive behaviours recently, but the behaviours had been ongoing for a while. Furthermore, the PSW stated that resident #001 typically displayed responsive behaviours to staff during periods of care.

The home's policy titled "Responsive Behaviours" last reviewed June 6, 2016, indicated that for each resident demonstrating responsive behaviours, their plan of care must at minimum address; behavioural triggers, strategies to respond to these behaviours, interventions and strategies for eliminating reversible causes, where applicable.

In an interview with the Inspector, the DOC stated that there were no behavioural triggers identified in resident #001's plan of care. The DOC stated that the responsive behaviours for resident #001 should have been indicated within their plan of care so staff were able to effectively respond to the resident's behaviours. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible and strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #7: 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 has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

Inspector #638 observed on October 12, 2016, the medication cart was left unlocked and unattended on the Sunny Side home area on multiple occasions between 1145 hours and 1155 hours. During this period RPN #103 was administering medications in the dining area while staff, family and residents were within the vicinity of the unlocked and unattended medication cart.

In an interview with the Inspector, RPN #103 stated that an in-service from the medical pharmacy was provided on September 21, 2016, which stated that medication carts could be left unlocked when in sight of a nurse during a medication pass. The inspector reviewed the legislative requirements laid out within the O.Reg with RPN #103 which, stated that the medication cart must be kept locked at all times, when not in use.

The Inspector observed on October 17, 2016, the medication cart in the dining room of the Lake View home area, left unlocked and unattended for at least five minutes while registered staff assisted residents with their dining service.

The Inspector interviewed RPN #109, who stated that the medication carts should be kept locked while not in use. In a concurrent interview, RPN #109 stated that this was necessary to prevent residents, staff or family from potentially accessing items within the cart.

In an interview with the Inspector, the DOC stated that the medication cart should remain locked whenever the cart was left unattended even during a medication pass. [s. 130. 1.]

Issued on this 3 day of March 2017 (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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
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SUDBURY, ON, P3E-6A5
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHAD CAMPS (609) - (A1)

Inspection No. / No de l'inspection : 2016_273638_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 020539-16, 020541-16, 020575-16, 020576-16, 020577-16, 020578-16, 020579-16, 020580-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Mar 03, 2017;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

LTC Home / Foyer de SLD : ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Roger Leveille

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_264609_0007, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

The licensee shall retrain all staff (PSWs, RPNs and RNs) who provide direct care to residents on the home's policies and procedures related to bed rails and their responsibilities to ensure bed rail safety and maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident.

During inspection #2016_264609_0007, compliance order (CO) #002 was served on June 6, 2016, related to bed rail systems, which ordered the licensee to;

"a) Develop and implement an assessment tool to ensure that every resident that uses bed rails is assessed and their 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.
b) Maintain a record of every resident specific assessment completed for the safe use of bed rails and if any assessment failed when and what the home did to address the safety risk.
c) Provide retraining to all staff who provide direct care to residents on the home's policies and procedures related to bed rails and their responsibilities to ensure bed rail safety.
d) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, b and d", section "c", where the licensee was ordered to ensure that all staff of the home were to have completed re-training related to the home's bed rails policies and procedures was not completed.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to the home's bed rails program which indicated that 21 out of 103 staff or 20 per cent of the home's staff did not complete the required re-training.

In an interview with the Inspector, the ADOC stated that all staff should have completed the required re-training as specified within the order report submitted to the home on June 6, 2016. [s. 15. (1) (a)]

During previous inspections (#2016_264609_0007) a CO was served on June 6, 2016, related to O. Reg 79/10, s. 15. (1). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm and although the scope was isolated, there is a compliance history including one CO previously issued in this area of the legislation. (638)

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

May 15, 2017(A1)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_264609_0007, CO #003;

Pursuant to / Aux termes de :

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

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

The licensee shall ensure that all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital and any other time when a resident is exhibiting altered skin integrity, including pressure ulcers, skin breakdown, skin tears or wounds.

Grounds / Motifs :

1. The licensee has failed to ensure that every resident at risk of altered skin integrity had received a skin assessment by a member of the registered nursing staff, upon the return of the resident from hospital.

During inspection #2016_264609_0007, CO #003 was served on June 6, 2016, whereby, the licensee was ordered to identify all residents who had altered skin integrity and ensure interventions were implemented to address the skin integrity issues. The licensee was also ordered to provide retraining to nursing and personal support staff related to the Skin and Wound Care program.

A complaint was submitted to the Director, which indicated that resident #002 had been hospitalized due to health complications.

The Inspector reviewed resident #002's health care record during the time period surrounding their hospitalization, which failed to identify any skin assessments completed upon their return to the home from the hospital.

In an interview with the Inspector, RN #115 stated that upon a resident's return to the home from hospital, a head to toe skin assessment should have been completed.

The Inspector reviewed the home’s policy titled, “Re-Admission From Hospital” last reviewed June 6, 2016, which indicated that it was the duty of the home's registered staff to ensure that a head to toe skin assessment was completed upon re-entry to the home.

The Inspector conducted a follow up record review with the DOC. The DOC was unable to identify any skin assessments which were completed upon resident #002's return from the hospital. The DOC stated that the required head to toe skin assessment would have been documented within the assessments tab in Point Click Care (PCC) and it was not. [s. 50. (2) (a) (ii)] (638)

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

A complaint was submitted to the Director, related to new instances of altered skin integrity of an unknown origin that resident #028 had sustained.

Inspector #638 reviewed the progress notes of resident #028, which indicated that the resident had exhibited a new instance of altered skin integrity, and that it was brought forward to the RN by family. In a review of the completed assessments on resident #028, the Inspector failed to identify any formal assessment that had been completed for the resident when the new area of altered skin integrity was discovered.

In an interview with the Inspector, RPN #109 stated that whenever a resident developed a new skin integrity concern, a skin alert assessment would have been completed in order to monitor the status of the wound.

In an interview with the Inspector, the DOC stated that there was no formal wound assessment completed for resident #028. The DOC then stated that there should have been an assessment completed for any new incident of altered skin integrity. [s. 50. (2) (b) (i)]

During previous inspections (#2014_282543_0017 and #2016_264609_0007) a Written Notification (WN) was issued to the home on June 20, 2014, related to skin assessments not being completed on residents and a CO was served on June 6, 2016, related to O. Reg 79/10, s. 50. (2). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm of the residents of the home exhibiting altered skin integrity and the scope for this issue was a pattern, there is a compliance history including one CO previously issued in this area of the legislation. (638)

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

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

Mar 17, 2017

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2016_264609_0007, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee shall:

a) Provide retraining to all staff involved in the care of residents or the operation of the home in the policies and procedures of the home related to complaints, specifically on the roles and responsibilities of each staff member in reporting, tracking and dealing with all written and verbal complaints received by staff in the home.

b) Provide retraining to the home's management team focusing on their roles and responsibilities in responding to, tracking and resolving complaints.

c) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that a documented record was kept in the home which included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to have been taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

During inspection #2016_264609_0007, CO #007 was served on June 6, 2016, whereby, all staff of the home were required to have completed re-training related to the home's complaint policy. This education was to have been completed by July 31, 2016.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to the home's complaint program, which indicated that 45 of 109 staff or 29 per cent of the home's staff had not completed the required re-training.

In an interview with the Inspector, the ADOC stated that all staff should have completed the required re-training as ordered during inspection #2016_264609_0007.

In an interview, the Administrator stated that all staff should have completed the required re-training on the complaint policy and that 45 active staff members had not completed the training prior to the follow-up inspection. [s. 101. (2)]

During previous inspections (#2016_264609_0007) a CO was served on June 6, 2016, related to O. Reg 79/10, s. 101. (2). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm to the residents in the home when complaints were not responded to appropriately and although the scope was isolated, there is a compliance history including one CO previously issued in this area of the legislation. (638)

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

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

May 15, 2017(A1)

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2016_264609_0007, CO #008;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #002, #025 and #027.

b) Develop and implement a system to ensure that all front line staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.

c) Provide retraining to all staff (PSWs, RPNs and RNs) involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care and maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

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

During inspection #2016_264609_0007, CO #008 was served to the licensee on June 6, 2016, related to plan of care, which ordered the licensee to;
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care.
b) Perform an assessment of all residents to identify which residents require special treatments including but not limited to oxygen therapy, bed alarms and hip protectors, to ensure that the plans of care for the identified residents include all interventions to manage their special treatments and that it is up to date.
c) Perform an assessment of all residents to identify which residents of the home are experiencing pain, to ensure that the plans of care for the identified residents include all interventions to manage their pain and that it is up to date.
d) Perform an assessment of all residents to identify which residents of the home have resistance to care, wandering and any other responsive behaviours, to ensure that the plans of care for the identified residents include all interventions to manage their behaviours and that it is up to date.
e) Perform an assessment of every resident of the home to identify which residents

require incontinence care, to ensure that the plans of care for the identified residents include all interventions to manage their incontinence and that it is up to date.
f) Perform an assessment of every resident of the home to identify which residents require oral hygiene oral hygiene assistance, to ensure that the plans of care for the identified residents include all interventions to manage their oral hygiene needs and that it is up to date.
g) Ensure that the oral hygiene required by resident #001 is provided to the resident as specified in the resident's plan of care, regardless of the staffing levels in the home.
h) Perform an assessment of every resident of the home to identify which residents required specific instruction to be followed by staff related to resident positioning in chairs and beds, to ensure that the plans of care for the identified residents include all interventions related to positioning and that it is up to date.
i) Ensure that the two bed baths per day identified in the plan of care for resident #022 that are required to maintain the resident's skin integrity are provided regardless of the staffing levels of the home.
j) Provide retraining to all staff involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care. The retraining must also include focused education to direct care staff involved in the care of any of the residents identified in the required assessments that resulted in changes to the plans of care.
k) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, c, e, f, h, i and k", sections "b, d, g and j" were not completed at the time of inspection.

During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016, the licensee was ordered to have performed an assessment of all residents to identify which residents of the home required special treatments, to ensure that the plans of care for the identified residents included all interventions to manage their special treatments and that it was up to date.

Inspector #638 reviewed three residents (#025, #026 and #027) identified by the personal support staff, who required special treatments and reviewed their care plans to ensure they were current to the resident's assessed needs and preferences.

a) Observations made on October 12, 2016, indicated resident #027 had a specific device to be used while the resident was in their wheelchair.

Inspector #638 conducted a record review of resident #027's care plan, which indicated that the resident was to have their specific device at all times while sitting in their wheelchair as an intervention.

In an interview with the Inspector, RPN #103 stated that resident #027 required this device on at all times while sitting in their wheelchair.

The home's policy titled "Care Planning", last reviewed November 19, 2015, indicated that staff were expected to ensure that care was provided to the resident as set out within the plan.

In an interview with the Inspector, the DOC stated that the care should have been provided as per the plan of care.

b) Observations made of resident #025 during their dining service on October 12, 2016, showed the resident #025 had a transferring device under them while seated in their wheelchair.

Inspector #638 reviewed the care plan for resident #025 which indicated that the transferring device was to be removed and could not remain under the resident as an intervention to their impaired skin integrity focus.

The Inspector conducted an interview with PSW #102 who stated that the transferring device must be removed whenever the resident was seated in their wheelchair as specified within their care plan.

In an interview with the Inspector, PSW #107 stated that the resident had specific responsive behaviours and the transferring device was left under the resident during those periods. The Inspector reviewed the care plan for resident #025 with PSW #107 which gave no indication that the transferring device was to be left under the resident at any time. PSW #107 then stated that the transferring device should have been removed as indicated in the care plan. [s. 6. (7)]

2. During inspection #2016_264609_0007, CO #008 was served to the home on June 6, 2016, the licensee was ordered to ensure that resident #001 received their

oral hygiene requirements as specified in the resident's plan of care, regardless of the staffing levels in the home.

Inspector #638 conducted a record review of resident #001's care plan which indicated that the resident's oral hygiene requirements directed staff to perform specific interventions each evening for the night as well as provide specific interventions after each meal.

A review of the oral hygiene records for resident #001 over a two month period, indicated that the oral hygiene care was only signed for in the mornings and evenings, with the exception of four days where the oral hygiene record was only signed once for the day.

In an interview with the Inspector, PSW #100 stated that resident #001 did not always eat large amounts of their meal and as a result oral hygiene was not done after each meal. In a concurrent interview with PSW #100 it was determined that the plan of care stated that the resident required oral hygiene performed after each meal as per the physician's request. The PSW stated that the care should have been provided as per the plan of care. [s. 6. (7)]

3. A complaint was submitted to the Director regarding an incident of resident #002, which resulted in actual harm, requiring the resident to be sent to the hospital where they passed away. The complaint letter indicated that resident #002's specific interventions were not implemented at the time of the incident.

Inspector #638 conducted a review of the care plan implemented for resident #002 at the time of the incident, it was determined that the resident was required to be wearing a specific intervention as an intervention related to their risk for falls. The Inspector reviewed the progress notes for resident #002 which indicated the resident had suffered an injury. The progress notes indicated that it was not clear if the resident's specific intervention was implemented prior to the incident. In a review of the application record for resident #002, it was determined that the intervention was not implemented at the time of their incident.

In an interview with PSW #118, it was verified that the intervention had not been implemented as specified within the plan of care at the time of the incident. PSW #118 stated that the resident had not been checked at the beginning of their shift in order to determine if the specific intervention had been implemented.

In an interview with the Inspector, the DOC stated that resident #002 did not have their intervention implemented at the time of the incident. The DOC stated that the care set out in the plan was not provided to the resident as specified in their plan to ensure that the resident's assessed needs were met. [s. 6. (7)]

4. During inspection #2016_264609_0007, CO #008 was served on June 6, 2016, the licensee was ordered to re-train all staff involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to the home's care plan policies and procedures which indicated that 19 of 103 staff or 18 per cent of the home's staff had not completed the required re-training related to the home's care planning program. This education was to have been completed by July 31, 2016.

In an interview, the ADOC stated that all staff were to have completed the re-training regarding the home's care planning program and that 19 active staff members had not completed the training prior to the follow up inspection. [s. 6. (7)]

During previous inspections (#2013_138151_0032, #2015_320612_0020 and #2016_264609_0007) a Voluntary Plan of Correction (VPC) was issued to the home on January 8, 2015 and a CO was served on January 8, 2015, and on June 6, 2016, related to LTCHA, 2007, s. 6. (7). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm of the residents of the home, who are not provided care as specified in their plans, the scope was a pattern, which included a compliance history including one CO previously issued in this area of the legislation. (638)

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

May 15, 2017(A1)

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

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_264609_0007, CO #006;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that every resident is reassessed and their plan of care is reviewed and revised whenever the resident's care needs change or care set out in the plan is no longer necessary, including but not limited to the plan of care for resident #026.

b) Develop and implement a monitoring system to ensure that when residents' needs change that they are reassessed, their plans of care revised, that staff are aware of the changes and provide care to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's plan of care was reviewed

and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During inspection #2016_264609_0007, CO #006 was served on June 6, 2016. The licensee was ordered to ensure that every resident was to have been reassessed and their plans of care reviewed and revised whenever the resident's care needs changed. The licensee was also ordered to have developed and implemented a monitoring system to ensure that when the needs of the residents change, that their care plans would reflect the changes.

a) Inspector #638 reviewed the care plan for resident #026, which indicated that the resident required interventions related to their area of altered skin integrity.

The Inspector reviewed the progress notes and assessment records of resident #026 which failed to have documented any assessments or notes indicating that the resident had any skin integrity issues.

A review of the physician medical directives indicated that these interventions had been discontinued on a specific day in September 2016.

In an interview with RPN #109, it was determined that resident #026 did not have any areas of altered skin integrity at the time and that the care plan should have been updated when the treatment was discontinued as the wound had been resolved.

The Inspector interviewed the Administrator and DOC, who stated that the plan of care should have been reviewed and revised when the care needs of a resident change.

b) Inspector #638 conducted a record review of resident #026's care plan, which indicated that staff would refer to the electronic Medication Administration Records (eMAR) for pharmacological analgesics related to the resident's risk for pain focus within the care plan.

In an interview with the Inspector, RPN #113 stated that resident #026 did not receive any pharmacological analgesics and had no interventions related to pain as the resident did not have a significant history of pain.

The Inspector and ADOC reviewed resident #026's physician ordered medications,

which indicated that the resident had no ordered pharmacological analgesics. The ADOC verified that the resident did not have any ordered analgesics and the care plan required to be updated.

c) During inspection #2016_264609_0007, a compliance order was served on June 6, 2016, whereby the licensee was ordered to develop and implement a monitoring system in order to ensure that when a resident's care needs changed that they were reassessed and their plan of care revised, so that staff were aware of the changes and provided care to the resident as specified, with a compliance date of July 31, 2016, to have the system implemented.

In an interview with the Inspector, the DOC stated that the home was in the process of developing a monitoring tool to assess the needs of the residents and to ensure that their care plans were kept up to date with relevant information. The Administrator stated that the monitoring system had not been finalized and had not been implemented in the home. [s. 6. (10)]

During previous inspections (#2016_264609_0007) a CO was served on June 6, 2016, related to LTCHA, 2007, s. 6. (10). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm to the residents in the home related to the lack of revisions of residents plans when their care needs changed and the scope was widespread, there is a compliance history including one CO previously issued in this area of the legislation. (638)

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

May 15, 2017(A1)

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2016_264609_0007, CO #005;

Pursuant to / Aux termes de :

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

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall:

a) Ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, focusing on how staff are to position residents in their wheelchairs during and post meal services.

b) Provide retraining to all staff (PSWs, RPNs and RNs) involved in the direct care of residents on the home's policies and procedures related to proper techniques for assisting residents with feeding and maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During inspection #2016_264609_0007, CO #005 was served on June 6, 2016, related to dining and snack services, which ordered the licensee to;
"a) Ensure that the daily and weekly menus are communicated to residents and that this information is properly communicated to residents regardless of staffing levels within the home.
b) Perform an assessment of every resident of the home that utilizes a tilt chair to ensure that the plan of care gives clear direction to staff regarding the positioning of the residents during and after meals.
c) Ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs and that the resident's plan of care gives clear direction to staff as to how to serve each resident.
d) Ensure that all eating aids, assistive devices, and staff assistance are provided to every resident to safely eat and drink as comfortably and independently as possible, focusing on how staff are to provide encouragement to feed with residents.
e) Provide retraining to all staff involved in the direct care of residents on the home's policies and procedures related to proper techniques for assisting residents with feeding, that staff do not feed more than two residents at a time, as well as the roles and responsibilities of each staff member to ensure compliance with the cited policies and procedures.
f) Maintain a record of the required retraining, who completed the retraining, when

and what the retraining entailed."

This order was to have been completed by July 31, 2016. While the licensee had complied sections "a, b, c and f", sections "d and e" had not been complied at the time of the inspection.

a) During inspection #2016_264609_0007, a CO #005 was served on June 6, 2016. The licensee was ordered to ensure that all eating aids and resident specific assistance needs including the positioning of residents, was provided to the residents as required.

During dining observations by Inspector #638 on October 12, 2016, the Inspector noted that resident #025 and #027 both had been positioned in a particular manner, while eating their lunches.

The Inspector reviewed the care plan for resident #027, which gave no indication that they were to be positioned in the manner that they were during the observations. Resident #025's care plan indicated; under the "Eating & Nutritional Needs" focus that the resident was to be seated in a specific manner to minimize their risk of choking or aspiration, which was opposite to how they were actually positioned during their meal.

In an interview with the Inspector, RPN #106 stated that residents were positioned for meals as specified within their plans of care in order to reduce any potential safety risk to the residents. RPN #106 reviewed the care plan for resident #027 and stated that there was no indication that the resident was to have been positioned in the manner that they were and they should not have been positioned in that manner.

During an interview with the Inspector, PSW #101 stated that resident #027 required to be positioned in a specific position during meal times to ensure that they swallow their food effectively and minimized their risk of choking.

The Inspector interviewed the DOC, who said that each resident had been assessed to determine their needs and that their specific direction was laid out within the plan of care. In a concurrent interview with the DOC it was determined that proper techniques should have been used to assist residents with their meals, including safe positioning to ensure that the resident was assisted with eating in a manner according to their assessed needs.

b) During inspection #2016_264609_0007, a CO #005 was served on June 6, 2016, where all staff of the home were ordered to have completed re-training related to the home's policies and procedures related to proper techniques for assisting residents with feeding, that staff would not feed more than two residents at a time, as well as the roles and responsibilities of each staff member, this education had a compliance date of July 31, 2016.

Inspector #638 reviewed the home's staff training records as of October 12, 2016, related to proper feeding techniques to assist residents with eating, which indicated that 20 of the 108 active staff or 18 per cent had not completed the required re-training in the allotted time.

In an interview with the Inspector, the DOC confirmed that the 20 staff members who had not completed the re-training were actively working within the home and that all staff should have completed the education on proper techniques to assist residents with eating by the compliance date. [s. 73. (1)]

During previous inspections (#2015_282542_0003, #2014_282543_0017, #2014_210169_0005 and 2016_264609_0007) a WN was issues to the home May 8, 2015, a VPC was issues on June 20, 2014 and a CO was served on March 17, 2014, and on June 6, 2016, all related to O. Reg. 79/10, s. 73. The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm and although the scope was isolated, there is a compliance history including one CO previously issued in this area of the legislation. (638)

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

May 15, 2017(A1)

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

Ministère 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

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

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 3 day of March 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHAD CAMPS - (A1)

Service Area Office /
Bureau régional de services : Sudbury