Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 3, 4, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 23, 24, 25, 2012	2012_029134_0009	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge, 1803 County Road 2, BROCKVILLE, ON, K6V-5T1

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

ST. LAWRENCE LODGE
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

COLETTE ASSELIN (134), CAROLE BARIL (150), DARLENE MURPHY (103), JESSICA PATTISON (197), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DOC), the Assistant Directors of Care (ADOCs), residents, families, Presidents of Resident and Family Councils, Registered Nurses (RN), Registered Practical Nurses (RPN), Dietitian, Nursing Attendants (NA), Coordinator of Employee Benefits and Resident Accounts, RAI Coordinator, Food Service Workers, Food Service Manager, Activation/Pastoral Care Coordinator, Recreation therapists, Environmental Services Aids, Director of Support Services, Pharmacists, Manager of Environmental Services.

During the course of this inspection an RQI log # O-001040-12 was conducted.

During the course of the inspection, the inspector(s) conducted a walking tour, observed the dining service, reviewed residents' health care records, observed care, reviewed medical directives and bowel regime, the Emergency Medication policy, policy on food safety issues, Safe Medication Administration, Skin Care, Pressure Ulcer Wound Treatment, Surplus Drugs to be Destroyed, Administration of Routine Medication, Self Administration of Medication, Continuous Quality Improvement Program, Policies on Infection Control, Lost and Found Clothing, staffing schedules, medication storage areas, Prevention of Abuse and Neglect Policy, the Admission Handbook, the Activity Calendar, observed activities, and reviewed the Activity Policies and related forms.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1) 4, in that residents receiving tray service are not being monitored during meals.

Resident # 9587 was observed to receive a tray at the beginning of the noon lunch meal service on May 8, 2012 on Oak. The tray was observed to be left with the resident in his/her room throughout the meal service. No staff were observed to monitor the resident and the tray remained in the resident's room until approximately 1300hours when the resident's family member arrived.

The resident's family member confirmed that he/she often arrives to find a tray in the room untouched or that the resident hasn't eaten. The resident has been noted to have a pattern of monthly undesirable weight loss. The family member further stated that he/she feels it is appropriate for the resident to stay in his/her room for meal service as the resident gets upset in the dining room but wishes for more assistance with meals. The resident's family member stated he/she has hired a sitter to assist the resident with the supper meal.

A registered staff on Oak (S120) confirmed that staff will provide a tray for the resident but do not stay with the resident to provide assistance and will leave the tray in the resident's room unattended throughout the meal service. This registered staff (S120) reported that he/she will assist resident at the end of the meal service if he/she can complete his/her own tasks.

The home's Director of Care confirmed that it is the home's expectation that residents receiving tray service will have someone (staff/family/volunteer) present at all times during the tray service. (138)

On May 8, 2012 during dining observation of the lunch meal on Spruce the inspector observed that resident # 7 received a tray to his/her room and throughout the time the tray was in the resident's room the door was closed and there was no staff monitoring the resident.

On May 8, 2012 at 12:24 hours registered staff (S140) stated that there is no formal process for monitoring residents when eating in their rooms.

On May 15, 2012 during an interview with resident # 7, the resident stated that he/she eats all his/her meals in his/her room. The resident also stated that staff do not check in while he/she is eating her meals.

On May 16, 2012, nursing attendant (S132) stated that resident # 7 receives his/her meals at the same time as other residents are eating in the dining room and that a nursing attendant will return to pick up the tray, which the resident leaves outside her door. Nursing attendant (S132) also stated that they do not monitor resident # 7 during meals.

On May 16, 2012, registered staff (S131) stated that he/she had just delivered resident # 7's medications and that he/she would not be checking in on him/her during the supper meal. The registered staff member also stated that this resident has signed a waiver stating that he/she accepts the risk of eating in his/her room and so staff do not monitor the resident.

On May 17, 2012, the Assistant Director of Care for the second floor (ADOC S130) stated that resident # 7 is to receive each meal tray on a cart outside his/her room and is supposed to leave the door open while eating and then put the tray back out in the hallway for staff to pick up. ADOC (S130) also stated that there is no formal process in place and that staff have not been directed to monitor resident # 7 during meal service.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with the O.Reg 79/10 section 15 (2) (a) in that the resident's chairs in the dining rooms and activity rooms are not kept clean and sanitary.

It was observed that residents' chairs in the following areas where soiled and stained during the course of the on-site inspection:

On Pine in the dining room - 8 green chairs were stained and discolored and in the activity room - 2 green chairs were stained and discolored.
On Elm in the dining room - 5 green chairs were stained and discolored and in the activity room - 3 green chairs were stained and discolored.
On Birch in the dining room - 3 blue chair were soiled with food debris and in the activity room - 6 chairs were stained and discolored.
On Oak in the dining room - 12 blue chair were soiled with food debris and in the activity room - 2 blue chairs were stained and discolored.
On Spruce in the dining room - 6 blue chairs were soiled with food debris and in the activity room - 5 blue chairs were stained and discolored.
On Cedar - in the dining room there were 5 red chairs stained with food debris and in the activity room - 4 red chairs were stained and discolored.
On Maple in the dining room there were 6 red chair soiled with food debris and in the activity room -2 red chairs were stained and discolored.

The Environmental Services Manager (S145) was interviewed and he/she stated that the chairs in the common area are wiped once a week and daily if soiled.

The Food Service Manager (S146) was interviewed and he/she stated that the dining room chairs are cleaned by the kitchen staff once a week and wiped after meals if soiled.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all the home furnishings are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The following findings show that the licensee has failed to comply with LTCHA 2007, s. 20 (1) in that the licensee has not complied with their policy related to the investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

During stage 1 of the RQI, resident # 9420 stated that a staff member had treated him/her roughly and have yelled at him/her on occasion.

Upon further investigation the inspector discovered that an alleged incident of abuse/neglect was reported to the ADOC (S108) regarding a medication being withheld from resident # 9420.

The Licensee's policy on Abuse and Neglect of Residents, # 0202-02-05 defines neglect as the failure to provide necessary care, assistance, guidance or attention that causes, or is reasonably likely to cause the resident physical, mental or emotional harm. The policy also states that neglect includes denying the person any of the things that are essential to life including food, water, medications and medical treatment.

The Licensee's policy on Investigation of Resident Abuse and/or Neglect, # 0202-02-06 states that the incident investigation team will document all information obtained from the complainant on the Investigation Report Form and obtain written statements from the complainant, the resident (if possible), the person(s) implicated, and witnesses and have the statements dated and signed.

During an interview with ADOC (S108) on May 18, 2012 he/she stated that he/she had immediately conducted an investigation into the alleged case of abuse/neglect, but that he/she did not have any documentation to support the investigation.

During an interview on May 18, 2012 the DOC and Administrator stated that the home's expectation would be that the ADOC would document any investigation into an alleged case of abuse/neglect.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with their "Investigation of Resident Abuse and/or Neglect" policy # 0202-02-06, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 129 (1)(b) of the O. Reg. 79/10, in that not all controlled substances are kept in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Residents # 9569, #8, #9, #10 and #11 have orders for Lorazepam, a controlled substance. It was noted that these controlled substances were stored in the residents' individual medication compliance packs within the medication cart.

RPNs (S102), (S141), (S122) and (S113) as well as the DOC were interviewed and they stated the Lorazepam, is not stored in a separate area within the locked medication cart.
(150)(134)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg 79/10, section 134 (a) in that residents who take any drug or combination of drugs, including psychotropic drugs, received monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On May 4, 2012 at 2230 hour, resident # 12 received Trazadone 50mg for anxiety. There was no documented effectiveness on the Medication Administration Record or in the progress notes.

On May 3, 2012 at 1705 hour, resident # 13 received Hydromorphone HCL 4mg for breakthrough pain. There was no documented effectiveness on the Medication Administration Record or in the progress notes.

On May 1, 2012 at 2245 hour, resident # 13 received Trazadone HCL for anxiety. There was no documented effectiveness on the Medication Administration Record or in the progress notes.

On May 7, 2012 at 2300 hour, resident # 13 received Trazadone HCL for anxiety. There was no documented effectiveness on the Medication Administration Record or in the progress notes.

On May 6, 2012 at 2210 hour, resident # 9481 received Lorazepam for anxiety. There was no documented effectiveness on the Medication Administration Record or in the progress notes.

On May 1, 2012 at 0918 hour, resident # 14 received Trazadone for anxiety. There was no documented effectiveness on the Medication Administration or in the progress notes.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents taking any drug or combination of drugs, including psychotropic drugs, received monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The following findings show that the licensee has failed to comply with O. Reg. 79/10 s. 30 (2), in that they have not documented resident's responses related to recreation and social activity interventions.

During an interview with the Activation Coordinator (S137) on May 17, 2012, he/she stated that the expectation is for Recreation Therapists to document at least once per month in each resident's progress notes using an activation or behaviour note in Point Click Care.

During an interview with Recreation Therapist (S135) on May 17, 2012 he/she stated that he/she had not been documenting in resident progress notes and that he/she had just learned that he/she needs to start this practice of documentation.

During an interview with Recreation Therapist (S136) on May 17, 2012 he/she indicated that the only documentation completed for residents related to their activities is their attendance.

Upon review of the activation/behaviour notes for three residents the inspector found the following:

- For resident # 9556, there have been no activity-related notes made since January 12, 2011.

- For resident # 9501, there have been no activity-related notes made since October 19, 2011.

- For resident # 9452, there have been no activity-related notes made since June 21, 2011.

Furthermore, the April 2012 Activity Resident Assessment Protocols (RAPs) for residents # 9556 and #9501 do not discuss the resident's responses to activity-related interventions.

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 any actions taken with respect to a resident under a program, including assessment, reassessment, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 s. 8 whereby the licensee is required under Ont. Regs 79/10 s. 114 (2) to ensure written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

On May 15, 2012 during the lunch medication pass, RPN (S107) was observed administering medications to a selected group of residents. The RPN was observed to pre-sign for all medications for the selected group of residents prior to the administration of the medications.

The Licensee's "Safe Medication Administration Policy", #0401-02-34 specifies that all registered staff are familiar with, and follow the College of Nurses of Ontario Medication Practice Standard.

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 all registered staff use Safe Medication Management practices, specifically as it relates to pre-signing for medication administration, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to comply with the O. Reg 79/10 section 123 (b), in that the licensee's written emergency drug box policy # 0401-02-27 does not meet the legislative requirements.

The Licensee's policy # 0401-02-27 was reviewed. There is no indication of the location of the supply, the procedure and timing for reordering the emergency drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

Based on the Licensee's Emergency Drug Box policy, once a medication is ordered, the entire packet is assigned to the resident by writing the resident's name on the label. Furthermore, the dosage from the packet may be different than the dosage ordered. Registered staff are to indicate the number of tablets/capsules to use for each dose.

Staff (S117) reported that when the unit is short of Hydromorphone staff are to borrow the medication from Resident # 15. This medication is used as a back up to the emergency supply. Hydromorphone 2mg/ml dispensed for resident # 15 has been borrowed for two different residents between September and December 2011 and on seven occasions. This practice is not identified in their policy.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The following findings indicate that the licensee has failed to comply with O. Reg. 79/10, s. 229 (4) in that staff did not participate in the implementation of the infection prevention and control program.

On May 9 and 10, 2012, inspector #197 observed the following in the North tub room on Cedar: unlabeled nail clippers and nail clippings on the counter by the shower and unclean, unlabeled stained urinal on the back of the toilet.

2. The licensee failed to ensure all staff participate in the implementation of the infection prevention and control program.

On May 9, 2012 during an inspection of the Cedar tub/spa room, a urinal was found stored on the back of the toilet that was labeled "3rd". The urinal was noted to have a yellow/brown staining in the bottom of the urinal.

On May 15, 2012, a walk-through of the Cedar tub/spa room was done with the (ADOC)(S108) the same urinal was still present in the same location. The ADOC (S108) was asked who would use this urinal and he/she advised he/she did not know, he/she stated the expectation is to have no multi use items in the spa area.

On May 10, 2012 nail clippers with nail clippings evident in the clippers were found in the clean container within the tub/spa area. Staff were interviewed and indicated the clippers are taken by the night staff to be soaked in a Chemosterilant solution in the dirty utility room and returned to the spa area and placed in the clean container after the soaking/cleansing is completed. The ADOC (S108) confirmed the same and the home has a policy "Cleaning and disinfection of nail care equipment, 0505-14-05" which indicates the same. The clippers had not received cleaning as per the home policy.

3. On May 9, 2012 in the spa room on Cedar that there was an unlabeled blue cup with nail clippers and nail clippings, a white urinal with brown stains left on the the back of the toilet. It was also noted in the shower room on Cedar that there were a pair of nail clippers on the counter.

4. On May 15, Inspector # 103 interviewed ADOC # 108 as it relates to the brown stained urinal marked 3rd which was still found on the back of the toilet on Cedar.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.
4. Charges for goods and services provided without the resident's consent.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to comply with section 245 (4) of the O. Reg 79/10, in that charges for chiropody services were provided without residents' consent.

The Licensee does not have an agreement with those residents who are charged for chiropody services. As of December 2011, there were twenty three residents being billed for chiropody services without an agreement. Review of the Licensee's Purchase of Services Agreement demonstrated the cost of this service is not included as part of the Licensee's Purchase of Service Agreement. This was further confirmed by staff (S125).

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 section 34 (1) (a) in that several identified residents did not receive oral care to maintain the integrity of oral tissue, including mouth care in the morning and evening and cleaning of dentures.

Resident # 9498 was interviewed and reported to the inspector that his/her dentures are cleaned every night at bedtime and stated staff do not assist him/her with mouth care in the morning.

Nursing Attendant (S111) advised that the evening staff are responsible for the cleaning of dentures. He/she confirmed residents who wear dentures do not receive any oral care to maintain the integrity of the oral tissue.

Resident # 9404 has two dentures but wears only the top one. The resident's spouse was interviewed and reported to the inspector that the resident's upper dentures are not cleaned twice a day and that the resident's is not receiving oral care consistently. The spouse also stated that the resident's top denture is often soiled with food debris.

Resident # 9404's upper denture was observed by inspector # 134 on May 17, 2012 at 11:10h and food particles were noted on it. (134)

2. The licensee failed to comply with the O. Reg 79/10 section 34 (1) (c) in that one identified resident was not offered an annual dental assessment and other preventive dental services.

Resident # 9381 has his/her own teeth and he/she indicated that he/she can do his/her own mouth care. He/She reported that he/she is not offered an annual dental assessment and other preventative dental services.

The DOC and RN (S117) were interviewed and they indicated that resident # 9381 would be seen by a dentist if he/she had any dental problem but would not be offered dental services if he/she did not exhibit any symptoms.

On May 11, 2012, resident # 9501 was interviewed and he/she reported that mouth care was done once a day and dentures were brushed at night. This information was validated by NA (S118), who reported that he/she swabs the resident's mouth in the morning but does not clean the dentures.

RN # 117, indicated that the resident # 9105 has a tendency of removing his/her dentures when in bed and placing them directly on the top of the bedside table. The dentures were observed, by the inspector, sitting for several hours directly on top of the bedside table 3 times during the on-site inspection. This suggests that he/she is not getting the assistance required.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 37 (1) (a) and (b) in that the identified resident's dentures are not labeled and cleaned as per the requirement and there is an indication that he/she does does not receive assistance as required.

On May 11 2012, inspector # 134 observed that resident # 9501's dentures were not labeled as per the requirement.

2. On May 11, 2012, the inspector observed 3 unlabeled used deodorants in the Spa room on Pine.

On May 9, 2012, the inspector observed one unlabeled comb and brush full of hair in the Cedar Spa and one unlabeled comb and 2 unlabeled and used brushes in the Elm spa.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following subsections:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The following findings show that the licensee has failed to comply with O. Reg. 79/10, s. 65 (2)(b) in that the Licensee has not developed a schedule of the recreation and social activities offered during the evenings.

The April 2012 activity calendar indicates "activities" for eleven out of thirty evenings and the May 2012 activity calendar indicates "activities" for thirteen out of thirty-one evenings. Neither calendar specifies what activities are being offered on these evenings.

During an interview with Recreation Therapist (S136) on May 17, 2012 , he/she stated that the unspecified activities for these evenings are decided upon at the time by the residents and the recreation therapist.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with section 57 (2) of the LTCHA 2007, in that the licensee failed to respond in writing to concerns or recommendations raised at the Residents' Council meeting within 10 days of receiving the advice.

In the January 2012 Resident Council's minutes under the subject "open discussion" several concerns were raised related to; lost laundry, the doctor visiting resident in the dining room, the piano being played in the dining room at mealtime disturbing residents, name tags not being worn by all employees, fan over the tub blowing cold air. These concerns were not responded to in writing within 10 days of the Resident Council's meeting.

The Activation Coordinator/Pastoral Care (S137) acknowledged that a response is not provided in writing to the Chair of the Residents' Council within 10 days.

The Chair of the Residents' Council, Resident # 9457, reported that the management team listens to the concerns raised but does not get back to the Council with their response in writing.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following subsections:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 60 (2) of the LTCHA 2007, in that the licensee failed to respond in writing to concerns or recommendations raised at the Family Council meeting, within 10 days of receiving the advice.

At the Family Council meeting of April 19, 2012, concerns were raised related to insufficient dining room chairs in the Oak dining room, and a request was made for a Porter Wheel Chair to be made available to residents returning from an outing. No written response were provided within 10 days of the Family Council Committee Meeting.

The Activation Coordinator/Pastoral Care (S137) acknowledged that a response is not currently provided in writing to the Chair within 10 days of concerns being raised at the Family Council.

The Chair/Member of the Family Council reported that the licensee does not currently respond in writing to concerns or recommendations received from the Family Council within ten days of receiving the advice even though actions are being taken.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 78 (2) (d) in that the admission package does not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident.

On May 14, 2012 the admission package was provided to the inspector and upon review the inspector found that the package did not include an explanation of the duty to make mandatory reports.

During an interview with staff member (S125) on May 15, 2012, it was confirmed that the home had not included an explanation of the duty to make mandatory reports in their admission package.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCH Act 2007 s. 6 (1) (c) in that the plan of care is not providing clear direction to staff and others who provide direct care to residents.

Resident # 9501 has the habit of removing both dentures when in bed and placing them on top of the bedside table. It was observed on three occasions during the inspection that his/her dentures were left on top of the bedside table for several hours and not placed and soaked in a denture cup. There are no clear direction for staff in the care plan related to the resident's tendency to remove both dentures and the risk of loss and breakage.

During the resident observation in stage, resident # 9501 was observed wearing a brief. Staff indicated that they did not pull his/her pants all the way up because the resident requests to use the bedpan frequently. There are no indication in plan of care to indicate the resident uses the bedpan during the day when in bed.

Nursing Attendant (S118) and RN (S117) were interviewed. Both reported that resident # 9501 was incontinent and wearing briefs, that he/she is toileted before breakfast and after lunch. There are no indication in the plan of care specifying the resident's need to be toileted on day shift.

One other NA, who usually works the night shift was interviewed on May 17, 2012. He/she reported that the resident uses the bedpan on the night shift. There is no clear direction to staff noted on the care plan as it relates to the resident's use of the bedpan on the night shift.

Resident # 9404 suffered a CVA and has a right sided paralysis and has expressive aphasia. His/her right hand is fixed and difficult to open. On May 16, 2012, Inspector # 134 assessed the resident's hand and a foul odour was noted from it.

The plan of care was reviewed on May 9, 2012. There are no indication that a splint is to be applied to his/her right hand. Furthermore there are no specific approaches related to the need for passive range of motion exercise to the hand by nursing attendants. There are no clear direction provided to staff as it relates to promoting independence with washing parts of his/her body and helping with dressing.

2. The licensee failed to comply with section 6 (7) of the LTCHA 2007, in that the licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Resident # 9577 appears visually to be tall and thin and this is confirmed by the health record which records a low BMI of 15.9.

Resident # 9577 was assessed and care planned to receive large portions at meals as an intervention for weight maintenance. Multiple nursing staff reported that when resident does eat, he/she eats very well.

Resident # 9577 was observed at two meals to eat well and finish 100% of his/her meal however the resident had only been provided with standard portions at both meals and not large portions as indicated on the resident's care plan. Additional food was not offered to resident when his/her meal was finished.

The Food Service Workers interviewed confirmed that resident # 9577 did not receive large portions at the two meals observed.

Issued on this 29th day of May, 2012

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

Colette Asselin, LTCH Inspector #134

Ontario

Ministry of Health and Long-Term Care

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COLETTE ASSELIN (134), CAROLE BARIL (150), DARLENE MURPHY (103), JESSICA PATTISON (197), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2012_029134_0009
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 3, 4, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 23, 24, 25, 2012
Licensee / Titulaire de permis :	The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	ST. LAWRENCE LODGE 1803 County Road, #2 East, Postal Bag #1130, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TOM HARRINGTON

To The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére 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 : 001

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

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 ensure there is monitoring of all residents during meals, including residents eating in locations other than dining areas.

Grounds / Motifs :

1. 1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1) 4, in that residents receiving tray service are not being monitored during meals.

Resident # 9587 was observed to receive a tray at the beginning of the noon lunch meal service on May 8, 2012 on Oak. The tray was observed to be left with the resident in his/her room throughout the meal service. No staff were observed to monitor the resident and the tray remained in the resident's room until approximately 1300hours when the resident's family member arrived.

The resident's family member confirmed that he/she often arrives to find a tray in the room untouched or that the resident hasn't eaten. The resident has been noted to have a pattern of monthly undesirable weight loss. The family member further stated that he/she feels it is appropriate for the resident to stay in his/her room for meal service as the resident gets upset in the dining room but wishes for more assistance with meals. The resident's family member stated he/she has hired a sitter to assist the resident with the supper meal.

A registered staff on Oak (S120) confirmed that staff will provide a tray for the resident but do not stay with the resident to provide assistance and will leave the tray in the resident's room unattended throughout the meal service. This registered staff (S120) reported that he/she will assist resident at the end of the meal service if he/she can complete his/her own tasks.

The home's Director of Care confirmed that it is the home's expectation that residents receiving tray service will have someone (staff/family/volunteer) present at all times during the tray service. (138)

On May 8, 2012 during dining observation of the lunch meal on Spruce the inspector observed that resident # 7 received a tray to his/her room and throughout the time the tray was in the resident's room the door was closed and there was no staff monitoring the resident.

On May 8, 2012 at 12:24 hours registered staff (S140) stated that there is no formal process for monitoring residents when eating in their rooms.

On May 15, 2012 during an interview with resident # 7, the resident stated that he/she eats all his/her meals in his/her room. The resident also stated that staff do not check in while he/she is eating her meals.

On May 16, 2012, nursing attendant (S132) stated that resident # 7 receives his/her meals at the same time as other residents are eating in the dining room and that a nursing attendant will return to pick up the tray, which the resident leaves outside her door. Nursing attendant (S132) also stated that they do not monitor resident # 7 during meals.

On May 16, 2012, registered staff (S131) stated that he/she had just delivered resident # 7's medications and that he/she would not be checking in on him/her during the supper meal. The registered staff member also stated that this resident has signed a waiver stating that he/she accepts the risk of eating in his/her room and so staff do not monitor the resident.

On May 17, 2012, the Assistant Director of Care for the second floor (ADOC S130) stated that resident # 7 is to receive each meal tray on a cart outside his/her room and is supposed to leave the door open while eating and then put the tray back out in the hallway for staff to pick up. ADOC (S130) also stated that there is no formal process in place and that staff have not been directed to monitor resident # 7 during meal service. (138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 28, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 25th day of May, 2012

Signature of Inspector / Signature de l'inspecteur : Colette Asselin, LTCH Inspector #134

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

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