Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2016	2016_270531_0021	013550-16	Resident Quality Inspection

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

SUSAN DONNAN (531), BAIYE OROCK (624), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 6, 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2016.

The following intake logs were completed concurrently with this inspection;
Log #032386-15 related to abuse/neglect
Log #009369-16 related to staffing
Log #012079-16 related to provision of care
Log #001390-16 related to abuse/neglect
Log #007523-16 related to staffing
Log #013965-16 Follow up related to policies re: medication administration
Log #013966-16 Follow-up related to 24/7 nursing

During the course of the inspection, the inspector(s) spoke with residents, residents' families, Resident and Family Council representatives, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Laundry and Housekeeping staff, the Maintenance Supervisor, the Manager for laundry and housekeeping, the scheduling clerk, the receptionist, the RAI Coordinator, the Food Service manager, the Director of Care and the Administrator. During the course of the inspection, the inspectors conducted a walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, reviewed the homes staffing schedules, staffing plan and back up plan and appropriate policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medication for resident #041, #042, #043, #044 and #012.

Related to intake log # 013965-16.

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction of all drugs used in the home.
Review of the licensee's Administration of Medications-General Considerations policy number TC-1022.2 indicated that medications are administered within one hour of the scheduled time, except medications to be given with food, or before or after meal/food orders, which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult pharmacist or pharmacy provider.
Review of the licensee's electronic medication system identified that the administering nurse signs for the medication on the e-MAR and e-TAR system. The e-MAR and e-TAR system records the actual time that the residents medication was signed as administered by the nurse on the Medication Treatment Administration Record.

Related to resident #043:
It was identified that resident #043's 0800 hour medication were administered greater than one hour following the administration scheduled for an identified date thirty six minutes outside the hour time schedule.

Related to resident #044:
Review of resident #044's Medication Treatment Administration Record for a particular date it was identified that resident #044's 20:30 hour medications were administered greater than one hour following the administration scheduled time on a specified date 30 minutes outside the hourly schedule time.
Review of resident #044's Medication Treatment Administration Record for 0830 hour a particular date identified that resident #044's 0830 hour medications were administered greater than one hour following the administration scheduled time for that date , 22 minutes late.

Related to resident #042:

Review of resident #042's Medication Administration Record for a specified period, it was identified that resident #042's 1600 medication was administered on two occasions greater than one hour following the administration scheduled time ranging from two hours and sixteen minutes to two hours and forty seven minutes late.

Review of resident #042's physician orders and the Medication Treatment Administration Record for a specified period it was identified that the 20:30 hour medication was administered greater than one hour following the administration time on one occasion two hours and fourteen minutes late.
And resident # 042's 17:30 hour medication was administered greater than one hour following the administration time on a specified date, one hour and seventeen minutes late.

Related to resident #041:
Review of resident #041's Medication Treatment Administration Record for specified period identified that resident #041's scheduled medication scheduled it was identified that resident #041's 17:30 hour medication were administered greater than one hour following the administration scheduled time on one particular day, one hour and ten minutes late.

The licensee further failed to comply with the following:
Under O. Reg. 79/10 r.131.(2) drugs were not administered to residents in accordance with the directions for use specified by the prescriber. (as identified by written notification #7(1))
Under O. Reg. 79/10 r. 131.(4) permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical (as identified by written notification #7 (2))

A compliance order #001 under inspection report #2016_389601_0005 was issued in April, 2016 under O. Reg. s. 8 (1) with a compliance date of May 31, 2016.
This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices were considered when the decision to re-issue this CO was made. [s. 8. (1) (a)]

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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Review of the water temperature logs was completed by inspector #194 on June 13, 2016 for;
Cedar unit
May 30, 2016 Tub room 49.8
June 05, 2016 Tub room 50
June 05, 2016 Room 164 sink temp 49.3
June 13, 2016 Tub room sink 49.4

Maple/Oak
May 30, 2016 Oak tub room 51.2
May 31, 2016 Maple tub room 51.2
May 31, 2016 room 271 sink temp 53.4

June 01, 2016 Oak tub room 50.5
June 02, 2016 Oak tub room 51.5
June 06, 2016 Oak tub room 53.8
June 07, 2016 Oak tub room 54.3
June 08, 2016 Oak tub room 49.9
June 08, 2016 Maple tub room 53.4
June 09, 2016 Oak tub room 52
June 10, 2016 Sun room 54.6

The home's " Water Temperature Monitoring policy VII-H-10.26 was reviewed and directs:
The water temperature of the hot water serving all tub rooms, serveries and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed will not exceed 49 degrees Celsius and will be monitored daily once per shift in random locations where residents have access to water.
The maintenance personal will:
1. when notified or when unusual temperatures occur, adjust the hot water tanks or boiler temperature up or down depending on the water temperature readings.
2. Sign off in the book in the boiler room that the hot water tank temperature has been adjusted
3. After the hot water tank temperature is adjusted go and retest the water where the temperatures were outside of the normal range, by running the hot water tap for 5 minutes, inserting the water temperature thermometer into the stream of water for 15 seconds then reading the water temperature on the dial/panel.
4. In one hour go back and retest the water temperatures and record the temperatures, to ensure that the water temperatures are now in a normal range.
RN #103, RPN #106, #118, #124 and PSW #100 were interviewed and indicated that when the water temperatures were outside the range of 40-49 degrees Celsius, signage is placed at the source and maintenance is notified.

The maintenance supervisor indicated to the inspector that he has been in this new position at the home since February, 2016.
Inspector #194 asked the maintenance supervisor the process in regards to in the home. The maintenance supervisor indicated that the registered staff are responsible for taking the water temperatures on the units and recording them in the water log, if there are any discrepancies the staff notify the maintenance supervisor. He indicated that if a number of water temperatures are reported outside of the range of 40-49 degrees Celsius he will make adjustments to the water; if there is only one temperature that is outside of the

range than no action is taken. Inspector #194 reviewed the temperature logs and policy with the maintenance supervisor for the period of May 30-June 13, 2016 and he indicated that the water temperature at the boiler was adjusted June 10, 2016 because the frequency of elevated temperatures from the Maple/Oak units over the period. The maintenance supervisor indicated that he was not oriented to the maintenance policies; did not always adjust, retest the water temperature and record the temperatures, to ensure that the water temperature were in a normal range as per policy. [s. 90. (2) (h)]

2. The licensee has failed to ensure the temperature of the hot water serving all tubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

The water temperatures were reviewed from May 30, 2016 to June 13, 2016.
The following dates were found to have tub temperatures of less than 40 degrees Celsius.

Cedar unit:
June 02, 2016 tub room 37.1

Maple/Oak
June 13, 2016 Room 251,water temperature tested at 38.1

The home's " Water Temperature Monitoring policy VII-H-10.26 was reviewed and directs:
The water temperature of the hot water serving all tub rooms, serveries and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed will not exceed 49 degrees Celsius and will be monitored daily once per shift in random locations where residents have access to water.
The maintenance personal will:
1. when notified or when unusual temperatures occur, adjust the hot water tanks or boiler temperature up or down depending on the water temperature readings.
2. Sign off in the book in the boiler room that the hot water tank temperature has been adjusted
3. After the hot water tank temperature is adjusted go and retest the water where the temperatures were outside of the normal range, by running the hot water tap for 5 minutes, inserting the water temperature thermometer into the stream of water for 15 seconds then reading the water temperature on the dial/panel.
4. In one hour go back and retest the water temperatures and record the temperatures, to ensure that the water temperatures are now in a normal range.

RN #103, RPN #106, #118, #124 and PSW # 100 were interviewed and indicated that when the water temperatures were outside the range of 40-49 degrees Celsius, signage is placed at the source and maintenance is notified.

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Inspector #194 asked the maintenance supervisor the process in regards to in the home. The maintenance supervisor indicated that the registered staff are responsible for taking the water temperatures on the units and recording them in the water log, if there are any discrepancies the staff notify the maintenance supervisor. He indicated that if a number of water temperatures are reported outside of the range of 40-49 degrees Celsius he will make adjustments to the water; if there is only one temperature that is outside of the range than no action is taken. Inspector #194 reviewed the temperature logs and policy with the maintenance supervisor for the period of May 30-June 13, 2016 and he indicated that the water temperature at the boiler was adjusted June 10, 2016 because the frequency of elevated temperatures from the Maple/Oak units over the period. The maintenance supervisor indicated that he was not oriented to the maintenance policies; did not always adjust, retest the water temperature and record the temperatures, to ensure that the water temperature were in a normal range as per policy. [s. 90. (2) (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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to insure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made by inspectors during the course of the Resident Quality Inspection (June 6-17, 2016) and constitute potential risk related to infection control and resident safety:

Common areas:
Maple Bathing Centre – broken/missing wall tile on right lower wall on entry to tub room with sharp edge.
Cedar Wing – Tub room wall has a 10x30 cm area with plaster scarred/gouged and peeling off and numerous scratches; there is a long line (40cm) of cracked and detached tiles in the entry to the bathroom area. (#624)

Rm #125 -multiple drywall scratches and paint chipped areas on both corridor walls (#624)

Room #152 -numerous scratches along the right wall on entry into the room and a large unfinished drywall patch on the left lower wall. (#531)

Room #155 had numerous scratches/scaring to lower door frame, scratches on right entrance to washroom and along right washroom wall. (#624)

Room #179 multiple scarred/ gouged areas in the drywall to the right wall and door (#624)

Room # 172 – multiple /scratched/scarred drywall areas along the bedroom walls and washroom door.(#624)

Room #251, had small hole (size of orange) in wall by the door.(#194)

Room #255 had multiple holes in bathroom and bedroom walls by the door as well as near the dresser in front of the door.

Room #253 bathroom has patched walls, not painted, loose piece of plastic baseboard

by the door of the bathroom. (#194)

Room # 359 lower right corner drywall damaged, large rough, aged unfinished plastered areas and floor trim is detached from the wall for approximately 3-4 feet with sharp edges. (#531)

Room #367 left lower wall, three feet of the drywall gouged, heavily scarred; drywall plaster applied to some of the areas, aged; rough and unfinished. (#531)

Room #365 the wall at front entrance on the right side of the bed is heavily scarred;
-unfinished aged drywall patches along the lower 2 feet of the wall; and a 4 foot piece of floor trim detached and missing along this wall, with sharp edges.
-continues into the left lower 2 feet of the left bathroom wall.
-3 foot black, scarred areas below the window in resident's bedroom.
-right wall beside bed; lower 3 feet drywall heavily scarred, gouged and paint chipped with unfinished drywall patches at the head of the bed . (#531)

Room #363 right lower wall and corner black marks and minimal drywall damage and black marks. (#531)

Room #368 lower 3 feet of left wall heavily scarred and gouged
-3 foot black marks below window
-third floor center hall large brown water stains encompassing 6 approximately 24"x12" ceiling tiles. (#531)

All wall damage and missing trim are a safety concern to residents in the area. Holes, patched areas and unpainted surfaces make it difficult to properly clean and the missing trim areas were noted to have left sharp edges which can be a potential risk to residents.

The Maintenance supervisor was interviewed and indicated he is new to the position (February 2016) and has been completing some of the preventative maintenance but was not orientated to the maintenance policies. The maintenance supervisor indicated that there are no schedules and procedures in place for routine, preventative or remedial maintenance to address disrepair.
The Administrator was interviewed and told inspector #194 that currently there are no schedules and procedures in place for routine, preventative maintenance for the home to address the disrepair.

Areas of disrepair identified during the inspection were widespread in the home. The Maintenance manager and the Administrator both confirm that there are no processes in place for tracking, prioritizing and addressing the identified areas of disrepair, that work is constantly ongoing at the home.
Non- compliance had been issued for maintenance in September 2014. Widespread disrepair, no current schedules and procedures for routine, preventive and remedial maintenance put the residents at risk for potential injury. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's restraint policy was complied with whereby a physician order, consent and monthly and annual evaluations are not completed as specified in the policy.

The "Restraint Implementation protocols" policy # VII-E-10.00 directs;

Director of Care will:
-establish an interdisciplinary team to review and monitor the use of restraints.
-establish, maintain, and monitor a process to review, evaluate and trend the use of restraints in the home on a quarterly basis
-facilitate annual evaluation of the least restraint practices within the home ensuring;
* effectiveness of protocols are evaluated
* results of the evaluation and analysis of use are documented

*changes/improvements are promptly implemented; and
* a written record of the evaluation and analysis is retained

Registered Nurse/Practical Registered Nurse will:
-obtain a written physician or nurse practitioner order for the restrain usage to include: purpose, type and when the restraint will be used.
-Obtain a written consent for the initial restraint use, annually thereafter, and upon any change in the restraint order.

PSW or designate will:
-review resident's care plan and follow the recommended interventions
-apply a restraint to a resident according to manufacturer's specifications
-visually check resident every hour for safety and comfort and document on restraint record
-undo restraint and reposition resident every 2 hours before reapplying the restraint.

Review of the Restraint observation forms for a particular two week period were completed for resident's #029 and #025. Incomplete documentation of the "restraint observation form" for both residents was identified on the day shift.

Review of the Restraint observation forms for resident #004 for the period of two weeks it was identified that documentation was not completed as per policy.

Interviews with PSW #129, #117 and # 109 they indicated that the PSW's are responsible for the application of the restraint to residents and document in point of care (POC) that repositioning was being completed as per policy. PSW staff interviewed indicated that registered staff were completing the "Restraint observation form" for the residents and that registered staff were responsible for the hourly checks of the restraints.
In an interview with RPN #124 she indicated that registered staff were responsible for assessing the need of the restraint at the beginning of the shift and commenting on the form the affect of the restraint of the resident every shift. RPN #124 confirmed that on June 14, 2016 she did not complete the "restraint observation form" for resident #029 or #025.

Subsequently the during an interview with the DOC and review of the restraint policy she indicated that the policy was not complied with in regards to obtaining a physician order; a consent and she did not conduct a monthly or annual evaluation of the restraint. [s. 29.

(1) (b)]

2. The licensee has failed to ensure that the home's restraint policy was complied with whereby a consent was not obtained from resident #004 or the resident's substitute decision maker.

Review of the home's "Restraint Implementation protocols" policy # VII-E-10.00 directs;

Registered Nurse/Practical Registered Nurse will:
-obtain a written physician or nurse practitioner order for the restrain usage to include: purpose, type and when the restraint will be used.
-Obtain a written consent for the initial restraint use, annually thereafter, and upon any change in the restraint order.
Review of resident #004's health care record it was identified that a consent was not obtained from the resident or the resident's substitute decision maker for the restraint as specified in the policy. [s. 29. (1) (b)]

3. The licensee has failed to ensure that the restraint policy was complied with whereby there was no physician order for resident #025's front seat belt or table top.

Review of resident #025's health record indicate the following:
Resident #025 diagnoses include cognitive impairment requires a seat belt with front closer and a table top for positioning during meals.

Review of resident #025's health care records confirm that there is no physician order for the restraint as specified in the policy. [s. 29. (1) (b)]

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 restraint policy is complied with., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Resident Council President on June 10, 2016, when asked about the involvement of the Resident Council in the development and implementation of the satisfaction survey in the Home, she indicated that she has no recollection of the Resident Council being involved in any survey. She indicated that the only survey she has completed is a survey related to the activity programs in which staff from the activity department came around and asked residents about their satisfaction with the activities program.
In an interview with the Resident Council Assistant, who is also the Manager of Life Enrichment and responsible for the surveys, she indicated that she does not remember if the survey was ever given to residents in 2015 or 2016.
Subsequently the DOC was interviewed and confirmed that the surveys were not given to residents. Both the manager and the DOC said the surveys are sent to families annually with an invitation to the care conferences. The DOC also added that there is currently no clear process regarding the involvement of the Resident Council in the development and implementation of the satisfaction survey and that she is currently working on establishing a process. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA, 2007, s. 85. (3) whereby the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

In an interview on June 15, 2016, with the Family Council President she confirmed that the Family Council was not provided an opportunity to participate in the development, carrying out or acting upon the results of the satisfaction survey .
Subsequently the Life Enrichment Coordinator and Director of Care were interviewed and both confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

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 to seek the advice of the Residents' and Family Council in developing, carrying out, and in acting on its results, to be implemented voluntarily.

WN #6: 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:

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 O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 37 (1) whereby resident personal items were not labelled.

During the course of the inspection (June 6-17, 2016) the residents shared bathrooms and bath centres were observed to have used and unlabelled resident personal items:

The following unlabelled resident personal items were noted:

Cedar Wing bathing centre :
- a urinal hanging behind the toilet
-one used Alpen shower gel, one hair brush with hair

Maple Wing bathing centre
-one comb with hair,
-a unlabelled basket that contained used Old Spice, Speed Stick and other used roll-on deodorant products.

Oak Wing bathing centre :
-three unlabelled used April fresh roll on deodorants
–one unlabelled used hair brush and one used April fresh roll-on deodorant

Birch Wing bathing centre
-two unlabelled used Old Spice and other roll-on deordorants,
-two used combs

RM 267 shared bathroom
- Two used unlabelled toothbrushes
- One used hair brush
- A unlabeled wash basin
- A urinal hanging by the toilet grab bar

PSW #109, was interviewed and indicated to inspector #624 that resident personal care items are to be labelled in a basket in shared bathrooms and transported with the resident to and from the bathing centre.

Subsequently the DOC was interviewed and confirmed that personal care items should always be labeled.(624) [s. 37. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

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

Inspector #194 observed RPN #106 and RPN #118 during the 0800 hour Medication Administration and identified :

Resident #012 has a physician order for which specifies that the medication is to be administered after breakfast and at bedtime.

On June 09, 2016 RPN #106 administered the medication at 08:30 hours, prior to breakfast to resident # 012. RPN #106 indicated not being aware that the order stated resident #012 was to receive the medication after breakfast.

On June 14, 2016 RPN #118 administered the specified medication at 08:20 hours, prior to breakfast to resident #012. RPN #118 indicated to inspector #194 that she was aware

that the medication was to be given after breakfast, but stated resident is usually not finished eating until after 09:00 and she did not want to be outside of the time line for administration.

Resident #044 has a physician order to receive a specified medication which directs staff to administer the medication dependent on blood pressure readings. Review of blood pressure records for a two week period was completed and indicated that on four occasions there was no blood pressure recorded and the medication was administered to the resident. [s. 131. (2)]

2. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a treatment medication only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals.
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

PSW #120, #109 were interviewed and confirmed they were permitted to administer topical medication without training or supervision.

RPN #122 and #106 were interviewed and confirmed that they had not provided training or supervision to staff who are not otherwise permitted to administer a topical treatment medication.

The Director of Care was interviewed and stated it was her expectation that registered staff provide training and supervision to the personal support workers to administer topical treatment medications. [s. 131. (4)]

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531), BAIYE OROCK (624), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2016_270531_0021
Log No. / Registre no:	013550-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 11, 2016
Licensee / Titulaire de permis :	TRENT VALLEY LODGE LIMITED 195 Bay Street, TRENTON, ON, K8V-1H6
LTC Home / Foyer de SLD :	TRENT VALLEY LODGE LIMITED 195 BAY STREET, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BILL WEAVER JR

To TRENT VALLEY LODGE LIMITED, 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_389601_0005, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
a) educate all registered nursing staff and non-regulated staff administering treatment medications about policy # TC-1022.2 "General Considerations Administration of Medication General Guidelines" in a formal education session and evaluate staff comprehension of the contents of the policy following the session; in particular the session and evaluation must include the requirement in the policy to administer medication within one hour of the scheduled time and that medication including treatment creams are documented at the time the medication was given; and
b) educate all registered nursing staff and all staff who apply treatment creams related to the College of Nurses of Ontario Medication Practice standards, including the administration of medication and treatment creams to be given according to the scheduled times as prescribed by the physician, the management of medication errors, and appropriate actions to be taken in response to medication errors.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medication for resident #041, #042, #043, #044 and #012.

Related to intake log # 013965-16.

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction of all drugs used in the home.
Review of the licensee's Administration of Medications-General Considerations policy number TC-1022.2 indicated that medications are administered within one hour of the scheduled time, except medications to be given with food, or before or after meal/food orders, which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult pharmacist or pharmacy provider.
Review of the licensee's electronic medication system identified that the administering nurse signs for the medication on the e-MAR and e-TAR system. The e-MAR and e-TAR system records the actual time that the residents medication was signed as administered by the nurse on the Medication Treatment Administration Record.

Related to resident #043:
It was identified that resident #043's 0800 hour medication were administered greater than one hour following the administration scheduled for an identified date thirty six minutes outside the hour time schedule.

Related to resident #044:
Review of resident #044's Medication Treatment Administration Record for a particular date it was identified that resident #044's 20:30 hour medications were administered greater than one hour following the administration scheduled time on a specified date 30 minutes outside the hourly schedule time.
Review of resident #044's Medication Treatment Administration Record for 0830 hour a particular date identified that resident #044's 0830 hour medications were administered greater than one hour following the administration scheduled time for that date , 22 minutes late.

Related to resident #042:
Review of resident #042's Medication Administration Record for a specified period, it was identified that resident #042's 1600 medication was administered on two occasions greater than one hour following the administration scheduled time ranging from two hours and sixteen minutes to two hours and forty seven minutes late.

Review of resident #042's physician orders and the Medication Treatment Administration Record for a specified period it was identified that the 20:30 hour medication was administered greater than one hour following the administration time on one occasion two hours and fourteen minutes late.
And resident # 042's 17:30 hour medication was administered greater than one hour following the administration time on a specified date, one hour and seventeen minutes late.

Related to resident #041:
Review of resident #041's Medication Treatment Administration Record for specified period identified that resident #041's scheduled medication scheduled it was identified that resident #041's 17:30 hour medication were administered greater than one hour following the administration scheduled time on one particular day, one hour and ten minutes late.

The licensee further failed to comply with the following:
Under O. Reg. 79/10 r.131.(2) drugs were not administered to residents in accordance with the directions for use specified by the prescriber. (as identified by written notification #7(1))
Under O. Reg. 79/10 r. 131.(4) permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical (as identified by written notification #7 (2))

A compliance order #001 under inspection report #2016_389601_0005 was issued in April, 2016 under O. Reg. s. 8 (1) with a compliance date of May 31, 2016.
This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices were considered when the decision to re-issue this CO was made. [s. 8. (1) (a)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is hereby ordered to comply with O. Reg 79/10, s. 90 (2) (h) and s. 90 (2) (i) by updating the home's policy, "Water Temperature Monitoring", VIIH-10.26 to include:
-how notifications by the registered nursing staff will be made to the specified personnel such that immediate action can be taken to address water temperatures outside of the acceptable range,
-the required documentation by the registered nursing staff of the time the specified personnel was notified,
-the specific actions that will be immediately instituted by the registered nursing staff to ensure resident safety when water temperatures exceed the acceptable range,
-the specific actions that will be taken when tub baths and showers cannot be completed due to low water temperatures,
-how and where the specified personnel, who are designated as responsible for addressing water temperatures outside of the acceptable range, will document all actions taken and the time the action was taken.
Education will be provided to all registered nursing staff and all personnel identified as responsible for addressing water temperatures outside of the acceptable range to ensure full implementation of the policy.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Review of the water temperature logs was completed by inspector on June 13, 2016 for;

Cedar unit:
May 30, 2016 Tub room 49.8
June 05, 2016 tub room 50
June 05, 2016 room 164 sink temp 49.3
June 13, 2016 tub room sink 49.4

Maple/Oak
May 30, 2016 Oak tub room 51.2
May 31, 2016 Maple tub room 51.2
May 31, 2016 room 271 sink temp 53.4
June 01, 2016 Oak tub room 50.5

June 02, 2016 Oak tub room 51.5
June 06, 2016 Oak tub room 53.8
June 07, 2016 Oak tub room 54.3
June 08, 2016 Oak tub room 49.9
June 08, 2016 Maple tub room 53.4
June 09, 2016 Oak tub room 52
June 10, 2016 Sun room 54.6

The home's " Water Temperature Monitoring policy VII-H-10.26 was reviewed and directs:
The water temperature of the hot water serving all tub rooms, serveries and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed will not exceed 49 degrees Celsius and will be monitored daily once per shift in random locations where residents have access to water.
The maintenance personal will:
1. when notified or when unusual temperatures occur, adjust the hot water tanks or boiler temperature up or down depending on the water temperature readings.
2. Sign off in the book in the boiler room that the hot water tank temperature has been adjusted
3. After the hot water tank temperature is adjusted go and retest the water where the temperatures were outside of the normal range, by running the hot water tap for 5 minutes, inserting the water temperature thermometer into the stream of water for 15 seconds then reading the water temperature on the dial/panel.
4. In one hour go back and retest the water temperatures and record the temperatures, to ensure that the water temperatures are now in a normal range.
RN #103, RPN #106, #118, #124 and PSW # 100 were interviewed and indicated that when the water temperatures were outside the range of 40-49 degrees Celsius, signage is placed at the source and maintenance is notified.

The maintenance supervisor indicated to the inspector that he has been in this new position at the home since February, 2016 and has not been oriented to the maintenance policies.
Inspector #194 asked the maintenance supervisor the process in regards to in the home. The maintenance supervisor indicated that the registered staff are responsible for taking the water temperatures on the units and recording them in the water log, if there are any discrepancies the staff notify the maintenance supervisor. He indicated that if a number of water temperatures are reported outside of the range of 40-49 degrees Celsius he will make adjustments to the

water; if there is only one temperature that is outside of the range than no action is taken. Inspector #194 reviewed the temperature logs and policy with the maintenance supervisor for the period of May 30-June 13, 2016 and he indicated that the water temperature at the boiler was adjusted June 10, 2016 because the frequency of elevated temperatures from the Maple/Oak units over the period. He indicated he did not retest the water temperature and record the temperatures, to ensure that the water temperature were in a normal range.

The severity of elevated water temperature was assessed. Water temperatures that exceed 49 degrees Celsius pose a potential risk to residents from hot water scalding. The scope of the risk is widespread as it affects all residents and is especially a risk for residents who can independently use the bathroom facilities without being made aware of the higher water temperatures. Due to the scope and severity of this risk, a compliance order is being issued.

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure the;
1) Development of schedules and procedures for routine, preventive and remedial maintenance are in place in the home.
2) Development of a monitoring process to assess the effectiveness of maintenance practices in the home. The monitoring process will include a method;
-to identify residential and common areas requiring repair and document when work has been completed.
- re-education to all departments related to the process for completing "maintenance log forms in use in the home on each unit".
-to ensure that the Maintenance Supervisor conducts weekly audits, related to the home ,furnishings and equipment being kept safe and in a good state of repair.
-Monthly analysis of all "maintenance logs forms" received, ensuring work has been completed and identifying and addressing any deficiencies.

Grounds / Motifs :

1. The licensee has failed to insure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made by inspectors during the course of the Resident Quality Inspection (June 6-17, 2016) and constitute potential risk

related to infection control and resident safety:

Common areas:
Maple Bathing Centre – broken/missing wall tile on right lower wall on entry to tub room with sharp edge.
Cedar Wing – Tub room wall has a 10x30 cm area with plaster scarred/gouged and peeling off and numerous scratches; there is a long line (40cm) of cracked and detached tiles in the entry to the bathroom area. (#624)

Rm #125 -multiple drywall scratches and paint chipped areas on both corridor walls (#624)

Room #152 -numerous scratches along the right wall on entry into the room and a large unfinished drywall patch on the left lower wall. (#531)

Room #155 had numerous scratches/scaring to lower door frame, scratches on right entrance to washroom and along right washroom wall. (#624)

Room #179 multiple scarred/ gouged areas in the drywall to the right wall and door (#624)

Room # 172 – multiple /scratched/scarred drywall areas along the bedroom walls and washroom door.(#624)

Room #251, had small hole (size of orange) in wall by the door.(#194)

Room #255 had multiple holes in bathroom and bedroom walls by the door as well as near the dresser in front of the door.

Room #253 bathroom has patched walls, not painted, loose piece of plastic baseboard by the door of the bathroom. (#194)

Room # 359 lower right corner drywall damaged, large rough, aged unfinished plastered areas and floor trim is detached from the wall for approximately 3-4 feet with sharp edges. (#531)

Room #367 left lower wall, three feet of the drywall gouged, heavily scarred; drywall plaster applied to some of the areas, aged; rough and unfinished. (#531)

Room #365 the wall at front entrance on the right side of the bed is heavily scarred;
-unfinished aged drywall patches along the lower 2 feet of the wall; and a 4 foot piece of floor trim detached and missing along this wall, with sharp edges.
-continues into the left lower 2 feet of the left bathroom wall.
-3 foot black, scarred areas below the window in resident's bedroom.
-right wall beside bed; lower 3 feet drywall heavily scarred, gouged and paint chipped with unfinished drywall patches at the head of the bed . (#531)

Room #363 right lower wall and corner black marks and minimal drywall damage and black marks. (#531)

Room #368 lower 3 feet of left wall heavily scarred and gouged
-3 foot black marks below window
-third floor center hall large brown water stains encompassing 6 approximately 24"x12" ceiling tiles. (#531)

All wall damage and missing trim are a safety concern to residents in the area. Holes, patched areas and unpainted surfaces make it difficult to properly clean and the missing trim areas were noted to have left sharp edges which can be a potential risk to residents.

The Maintenance supervisor was interviewed and indicated he is new to the position (February 2016) and has been completing some of the preventative maintenance but was not orientated to the maintenance policies. The maintenance supervisor indicated that there are no schedules and procedures in place for routine, preventative or remedial maintenance to address disrepair.
The Administrator was interviewed and told inspector #194 that currently there are no schedules and procedures in place for routine, preventative maintenance for the home to address the disrepair.

Areas of disrepair identified during the inspection were widespread in the home. The Maintenance manager and the Administrator both confirm that there are no processes in place for tracking, prioritizing and addressing the identified areas of disrepair, that work is constantly ongoing at the home.
Non- compliance had been issued for maintenance in September 2014.
Widespread disrepair, no current schedules and procedures for routine, preventive and remedial maintenance put the residents at risk for potential injury. (194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2016

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

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 sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 11th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

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