Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 17, 2014	2014_248214_0027	H-001044-14	Resident Quality Inspection

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3

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

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3

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

CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129), YVONNE WALTON (169)

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): September 30, October 1, 2, 3, 7, 8, 9, 2014.

This Inspection Report contains findings of non-compliance identified during inspections conducted concurrently with the Resident Quality Inspection. Concurrent Critical Incident Inspections include: H-000841-14, H-000862-14, H-000968-14 and concurrent Follow Up Inspections include: H-000336-14, H-000337-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Support Services Manager, Environmental Supervisor, Registered Dietitian, registered staff, Health Care Aides (HCA)/Personal Support Workers (PSW), laundry staff, housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) interviewed staff, residents and families, toured the home, reviewed clinical records, relevant policies and procedures, home's investigative records, minutes of meetings and observed the provision of care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A. Resident #009's plan of care specified that an alarm was to be in place whenever the resident was in bed or sitting in the chair in order to manage a risk for falling. Clinical documentation indicated that on an identified date in April 2014, the resident was found to be sitting on the floor after climbing from the bed and that the bed alarm had not been applied. Staff and the clinical documentation confirmed that this care was not provided.

B. Resident #300's plan of care specified that the resident required the assistance of two staff to transfer the resident for toileting. Staff and clinical documentation confirmed that this care was not provided when on an identified date in July 2014, one staff transferred the resident for toileting, the resident fell and sustained a fracture. (129) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #001 was not reassessed and the plan of care reviewed or revised when at the time of this inspection the resident was noted to have identified wounds and skin issues. The ADOC confirmed that the resident had not been reassessed related to these identified wound and skin issues and the plan of care had not been revised to identify these issues or provide staff with directions on the care and treatment of the wounds or skin issues.(129) [s. 6. (10) (b)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Resident #009's plan of care was not reviewed or revised when the resident experienced multiple falls. The goal of care identified was to reduce the number of falls the resident was experiencing. Clinical documentation indicated that over an identified five month period in 2014, the resident fell seven times. The ADOC and clinical documentation confirmed that the plan of care was not reviewed during this identified period of time and the resident continued to experience falls.(129) [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 resident is reassessed and the plan of care reviewed and revised when the resident's care needs change and when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

Resident #300's plan of care identified that this resident required the assistance of two staff to safely transfer to the toilet. The resident's right to be cared for in accordance with their needs was not respected and promoted when on an identified date in July 2014, one staff attempted to assist the resident to transfer from the toilet. The resident was unable to completely stand without support due to a medical condition and fell in the bathroom which resulted in the resident sustaining a fracture. The resident indicated that at the time of this incident they told the staff person that they required two staff to assist with toileting and the staff person in attendance told the resident that there was no one else to help and preceded to assist the resident. The homes investigative notes also confirmed that transfer logos which indicated that the resident required two staff to assist them to the toilet, were posted at the resident's bed side at the time of this incident. [s. 3. (1) 4.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or the Regulation requires the licensee to put in place any policy, protocol or strategy that the policy, protocol or strategy is complied with.

The home's policy "Skin Breakdown Program" identified as #NUR-III-87 and revised in November 2011 directed:

i) The dietitian shall assess and make recommendations for nutritional support, including supplements as appropriate, for residents at risk and those with impaired skin integrity.

This direction was not complied with when the dietitian did not assess resident #001 when it was identified that this resident had wounds and skin issues or when it was identified that resident #013 had sustained multiple skin tears to identified areas.

ii) Each resident who exhibits skin breakdown shall be assessed each week or more frequently by a member of the registered nursing staff.

This direction was not complied with when resident #001 was not reassessed weekly when the resident demonstrated skin tears and pressure ulcers. This direction was also not complied with when resident #013 was not assessed weekly when they demonstrated multiple skin tears and a pressure ulcer to identified areas.

iii) The plan of care for each resident who has impaired skin integrity shall outline measures to be provided to promote healing and prevent skin breakdown.

This direction was not complied with when resident #013's plan of care did not include measures to promote healing of multiple skin tears or measures to prevent further injury. The ADOC confirmed that the plan of care had not included this information. (129) [s. 8. (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 where the Act or the Regulation requires the licensee to put in place any policy, protocol or strategy that the policy, protocol or strategy is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails were used, the resident was assessed in accordance with evidenced based practices or prevailing practices, to minimize the risk to the resident.

A) Resident #009's plan of care indicated that the resident uses bed rails to assist with bed mobility and bed rails are also included in the plan as interventions to manage a risk of falling. The ADOC confirmed that an assessment of the resident related to the risk of the use of the bed rails had not been completed.

B) Resident #012's plan of care indicated that the resident uses bed rails to assist with bed mobility and for safety. The ADOC confirmed that an assessment of the resident related to the risk of the use of the bed rails had not been completed.

C) Resident #013's plan of care indicated the resident uses bed rails as an intervention to manage a risk of falling. The ADOC confirmed that an assessment of the resident related to the risk of the use of the bed rails had not been completed. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when bed rails are used, the resident is assessed in accordance with evidenced based practices or prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Throughout the inspection, the resident handrails in the hallways were observed to be in an unsafe condition. The corners were chipped resulting in sharp edges and risk to residents' hands. The finish was worn off throughout all handrails. This was confirmed by maintenance and nursing staff. Several light fixtures throughout the home were not equipped with covers. Several ceiling tiles throughout the home were visibly soiled and stained. Several wall heaters were damaged, rusty and falling off the walls. This was confirmed by maintenance staff. Chairs throughout the home, especially in the dining and common areas were observed in a poor state of repair. The wooden finishes were worn off. Maintenance staff identified an ongoing re-finishing program was in place; however, the finishing was not sustainable for everyday use by residents. Several areas of the home had wall damage including holes in the walls and damaged baseboards. This was confirmed by maintenance staff and the Administrator.(169) [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the home was equipped with a resident-staff communication and response system that was properly calibrated so that the level of sound was audible to staff.

Several call bells were checked and nursing staff confirmed the call bells were not audible or extremely hard to hear. Rooms 220, 130, 114, 222 and 224 were all observed to be extremely faint. [s. 17. (1) (g)]

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 home is equipped with a resident-staff communication and response system that is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian.

A) The ADOC confirmed that resident #001 was not assessed by the Registered Dietitian when clinical documentation indicated that the resident demonstrated pressure ulcers and skin tears during identified dates in 2014.

B) The ADOC and clinical documentation confirmed that resident #013 was not assessed by the Registered Dietitian when staff documented that on four identified dates in 2014, the resident sustained a total of 13 skin tears.(129)[s.50.(2)(b)(iii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A review of the weekly skin assessment for resident #001 that was completed on an identified date in February 2014, indicated that resident #001 had pressure ulcers to identified areas. The following weekly assessment was not completed until 14 days later. The ADOC and clinical records confirmed that although the resident continued to have these pressure ulcers there were no further reassessments of the residents skin condition. A further review of the clinical documentation also indicated that resident #001 had a skin tear when staff completed a wound assessment on an identified date in May 2014. A subsequent reassessment completed one week later indicated the resident continued to have a skin tear. The ADOC and clinical documentation confirmed there were no further reassessments of the resident's skin condition.

B) The ADOC and clinical documentation confirmed that resident #013's skin integrity was not reassessed weekly when it was identified in August 2014 that the resident sustained skin tears and a pressure ulcer.(129) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian and is also reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating for residents who required assistance.

On an identified date in September 2014, it was observed during the lunch hour meal service on second floor, that a volunteer and two Personal Support Workers (PSW) were scraping food from the faces of several residents with a spoon and then feeding the scraped food back into the residents' mouths. The same residents also received pureed food that was stirred together by the volunteer and staff that were feeding them. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating for residents who require assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received annual retraining, in accordance with O.Reg. 79/10 s. 219(1) in the area of fall prevention and management and in accordance with O.Reg. 79/10 s. 221(1) 1 in the area of skin and wound care, in accordance with O. Reg 79/10 s. 221(1) 2.

A) Documentation provided by the home indicated that 20 of 89 staff who provided direct care to residents in 2013, did not receive training in the area of falls prevention and management.

B) The ADOC confirmed that 57 of 89 staff who provided direct care to residents in 2013, did not receive training in the area of skin and wound care. [s. 76. (7) 6.]

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 staff who provide direct care to residents receive annual retraining, in accordance with O.Reg. 79/10 s. 219(1) in the area of fall prevention and management and in accordance with O.Reg. 79/10 s. 221(1) 1 in the area of skin and wound care, in accordance with O. Reg 79/10 s. 221(1) 2, to be implemented voluntarily.

WN #10: 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:

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 licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) On an identified date in September 2014, staff were observed in the dining room on second floor clearing residents' soiled dishes from the tables and then wiping their soiled hands on the staff aprons. Staff then attended to feeding different residents and wiping residents' mouths with washcloths and aprons. No staff member was observed washing their hands during the meal service. One PSW did wash their hands at the end of the meal service only. There was no disinfectant bottles available for staff to use, except for on the medication cart. It was never used during the entire meal service of ninety minutes.

B) Call bell cords observed in dining areas was noted to be heavily soiled and made of non washable materials. This was confirmed by maintenance staff.(169) [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the residents altered skin integrity.

Clinical documentation indicated that resident #013 had demonstrated multiple skin tears on an identified date in 2014. The ADOC and clinical documentation confirmed that although registered staff completed skin assessments when the skin tears were identified, a plan of care was not developed and implemented related to the risk of skin tears or actions staff were to take to prevent further skin tears.(129) [s. 26. (3) 15.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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 licensee did not ensure that each of the organized programs under O. Reg. 79/10 s. 48 were evaluated and updated annually.

The ADOC confirmed that the home did not complete annual evaluations for the year 2013 related to the required program of fall prevention and management as well the required program for the management of skin and wound.(129) [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #013's quarterly Minimum Data Set (MDS) completed on an identified date in August 2014, indicated that the resident was coded as being incontinent for bladder. The resident's current written plan of care and kardex indicated that management of the resident's bladder incontinence included having their incontinent product checked every three hours while up and two times through the night; staff were to change the incontinent product when indicated and provide pericare for each incontinent episode. On two identified dates in October 2014, Personal Support Workers (PSW) had been observed to have checked the resident's incontinent product. An interview with the PSW's indicated that the resident was dry and did not require a change of their incontinent product. A review of the "Daily Flow Sheet", in which staff document care provided, indicated that documentation regarding checking the resident's incontinent product on the above dates had not been completed. An interview with Registered Staff and the ADOC confirmed that documentation only occurred on the "Daily Flow Sheet" and that the actions of checking the resident had not been documented as the "Daily Flow Sheet" only allowed documentation to be recorded once per shift in a 24 hour period.(214) [s. 30. (2)]

WN #13: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to 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.

An interview that was conducted on an identified date in October 2014 with the Residents' Council president and resident #201, a member of the Residents' Council, who indicated that the Satisfaction Survey was distributed in April 2014 and that the Residents' Council were not sought out for their advice in developing and carrying out the Satisfaction Survey. The Administrator confirmed that the advice of the Residents' Council and the Family Council was not obtained in developing and carrying out the Satisfaction Survey as the survey was developed and sent out by the home.(214) [s. 85. (3)]

2. The licensee failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice about the survey.

An interview that was conducted on an identified date in October 2014 with resident #201, a member of the Residents' Council, who indicated that the Satisfaction Survey was distributed in April 2014 and that the Residents' Council had not recieved the results of the Satisfaction Survey, to seek their advice. An interview with the Administrator confirmed that the results of the survey had not been documented and made available to the Residents' and Family Councils.(214) [s. 85. (4) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a sufficient supply of face cloths available in the home for use by the residents.

Observation in the home on identified dates in September and October, 2014, confirmed there was an insufficient amount of face cloths available in the dining areas and on linen carts on both home areas, to wash residents' faces after meals. On an identified date in September 2014, during the meal service on the second floor, observation revealed staff used large bath towels to wash residents' faces after the meal. The nursing staff all stated they usually use face cloths; however, they are rarely available. On an identified date in October 2014, during the meal service in the lower level, observation revealed staff used napkins to wipe residents' faces after the meal. The nursing staff all stated they wanted to use face cloths due to food sticking; however, they are rarely available. Laundry staff confirmed there was an insufficient amount of face cloths to provide to nursing staff for care. During the discussion in the laundry room, a Retirement home staff member came into the laundry room and removed a large pile of wash cloths to use in the Retirement home.(169) [s. 89. (1) (b)]

WN #15: 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,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment and devices were kept in good repair.

Resident #009 was identified as a risk for falling and interventions were in place including the use of an alarm whenever the resident was in the chair or in bed. Staff and clinical documentation confirmed that on an identified date in September 2014, the resident fell when the chair alarm that was in place did not function. The ADOC confirmed that the home had not developed or implemented procedures to ensure that alarms being used in the home were kept in good repair.(129) [s. 90. (2) (b)]

2. The licensee has failed to ensure that the toilet seats and washroom accessories were maintained.

On an identified date in September 2014, several toilet seats were observed to be loose. Several toilets which were equipped with a "versa frame" and were observed to be very loose and wobbly, creating a risk to residents. Room 201, 208, 212, 121, and 114 were observed to have toilet seats that were loose and the accessory/Versa Frame was also loose. Residents in rooms 114 and 102 confirmed they were loose as did housekeeping staff and maintenance staff. Maintenance staff confirmed they do not maintain the "versa frames" as they are purchased by family members.(169) [s. 90. (2) (d)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information provided for in section 78 of the Act included information about the following: 1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1).

A review of the LTCH Licensee Confirmation Checklist Admission Process that was completed by the home on September 30, 2014, indicated that the home had not included the resident's ability to retain a physician or registered nurse in the extended class to perform the services, in their admission package. An interview with the Administrator confirmed that the home had not included this information in their admission package to residents.(214) [s. 224. (1) 1.]

2. The licensee failed to ensure that the package of information provided for in section 78 of the Act included information about the following: 3. the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation.

A review of the LTCH Licensee Confirmation Checklist Admission Process that was completed by the home on September 30, 2014, indicated that the home had not included the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence in their admission package. An interview with the Administrator confirmed that the home had not included this information in their admission package to residents.(214) [s. 224. (1) 3.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the following requirements: 3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

A review of the LTCH Licensee Confirmation Checklist Quality Improvement & Required Programs that was completed by the home on September 30, 2014, indicated that the home had not communicated the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents, to the Residents' Council, Family Council and staff of the home on an ongoing basis. An interview with the Administrator confirmed that this information had been communicated to both the Residents' and Family Councils, but not to staff, as required.(214) [s. 228. 3.]

2. The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the following requirements: 4.ii. the names of the persons who participated in evaluations, and the dates improvements were implemented.

A review of the LTCH Licensee Confirmation Checklist Quality Improvement & Required Programs that was completed by the home on September 30, 2014, indicated that the home had not maintained a record of the names of the persons who participated in evaluations, and the dates improvements were implemented. An interview with the Administrator confirmed that the home had not maintained these records, as required.(214) [s. 228. 4. ii.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2014_247508_0008	214
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2012_205129_0006	214
O.Reg 79/10 s. 54.	CO #001	2014_247508_0008	214

Issued on this 27th day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2014_248214_0027
Log No. / Registre no:	H-001044-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 17, 2014
Licensee / Titulaire de permis :	BARTON RETIREMENT INC. 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	THE WELLINGTON NURSING HOME 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA BRENTNALL

To BARTON RETIREMENT INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that care set out in the plan of care is provided to all residents, including residents #009 and #300, as specified in the plans.

Grounds / Motifs :

1. Previously identified as non-compliant with a CO on March 21, 2013.

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

A. Resident #009's plan of care specified that an alarm was to be in place whenever the resident was in bed or sitting in the chair in order to manage a risk for falling. Clinical documentation indicated that on an identified date in April 2014, the resident was found to be sitting on the floor after climbing from the bed and that the bed alarm had not been applied. Staff and the clinical documentation confirmed that this care was not provided.

B. Resident #300's plan of care specified that the resident required the assistance of two staff to transfer the resident for toileting. Staff and clinical documentation confirmed that this care was not provided when on a specified date in July 2014, one staff transferred the resident for toileting, the resident fell and sustained a fracture. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2014

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that every resident is cared for in a manner consistent with their needs, including resident #300.

Grounds / Motifs :

1. Previously identified as non-compliant with a CO on June 30, 2012 and March 21, 2013.

The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

Resident #300's plan of care identified that this resident required the assistance of two staff to safely transfer to the toilet. The resident's right to be cared for in accordance with their needs was not respected and promoted when on an identified date in July 2014, one staff attempted to assist the resident to transfer from the toilet. The resident was unable to completely stand without support due to a medical condition and fell in the bathroom which resulted in the resident sustaining a fracture. The resident indicated that at the time of this incident they told the staff person that they required two staff to assist with toileting and the staff person in attendance told the resident that there was no one else to help and preceded to assist the resident. The homes investigative notes also confirmed that transfer logos which indicated that the resident required two staff to assist them to the toilet, were posted at the resident's bed side at the time of this incident. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 17th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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