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 soins 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
May 19, 2016	2016_395613_0003	001648-16	Resident Quality Inspection

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

LISA MOORE (613), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

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): February 22 - 25 and March 1 - 3, 2016

Additional logs conducted during the RQI include:
021921-15 related to a critical incident the home submitted related to the allegations of misuse/misappropriation of residents money
004489-15 and 000168-16 related a critical incident the home submitted related to the allegations of staff to resident abuse

004892-16 related to a critical incident the home submitted related to resident to resident abuse
004166-16 related to follow up on previous order for duty to protect
004178-16 related to follow up on previous order for reporting immediately to the Director
004167-16 related to follow up on previous order for falls and post falls assessments
004018-14 related to a critical incident the home submitted related to a fall of a resident requiring transfer to hospital
006011-16 related to respiratory outbreak with in the LTC home
005621-16 related to a critical incident the home submitted related to the water shut off with in the LTC home
006131-16 related to a critical incident the home submitted related to the magnetic locks on the doors malfunctioning.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Supervisor (FSS), Maintenance Supervisor, Acting Nutrition Manager, Activity Coordinator, Cook, Maintenance staff, Physiotherapy Assistance (PTA), Resident Assessment Instrument (RAI) Coordinator, Registered Staff (RNs and RPNS) and Personal Support Workers (PSWs), residents and family members.

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident heath care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **11 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_283544_0023	617
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2015_283544_0023	621
O.Reg 79/10 s. 49. (2)	CO #003	2015_283544_0023	613

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident were kept closed and locked.

During the initial tour of the home on February 22, 2016, Inspector #613 was able to open eight exit doors that led to outdoor non-residential areas. All of the exit doors led to a parking lot that surrounded the home. The alarm sounded when the Inspector opened each unlocked door.

During an interview, Maintenance #111 informed the Inspector that there was a problem with the magnetic locks. Maintenance #111 also stated that they had been aware of the issue since it occurred on January 21, 2016.

During an interview on February 22, 2016, with the Administrator, they informed the Inspector that they were not aware of the problems with the exit doors not locking.

During an interview, RN #102 informed the Inspector that all staff were aware that the magnetic locks on the exit doors were not working. RN #102 also stated that the alarm would still sound and alert staff if any of the doors were opened but, the doors would not

remain locked. RN #102 informed the Inspector to ensure resident safety, personal support workers and registered staff were conducting hourly checks of the doors and head counts of all the residents.

During an interview on February 25, 2016, with Maintenance Supervisor #110, they reported to the Inspector that the company to repair the doors would be in the home on Friday February 26, 2016.

During an observation on March 1, 2016, the Inspector noted that two doors were repaired; however, the remaining six doors in the home were not repaired. Maintenance #111 reported to the Inspector that the company was supposed to be back to the home on March 1, 2016 to repair the remaining doors but, they did not show. As reported by Maintenance #111, the company still needed to figure out where the short in the magnetic box was occurring in order to ensure all doors remained locked.

During an interview on March 3, 2016, with the Director of Care (DOC), they reported to the Inspector that they were unsure what the home had done to repair the magnetic lock malfunction on all of the exit doors. The Maintenance Supervisor had been off work. The home was unable to provide the Inspector with a log or tracking record to identify what they had done to repair the magnetic lock malfunctioning on the doors since January 21, 2016. The DOC confirmed that the magnetic lock malfunction had been an issue since January 21, 2016. [s. 9. (1) 1. i.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 there was a written plan of care for resident #009 that set out clear direction to staff and others who provide direct care to the resident.

Inspector #617 reviewed resident #009's health care record which indicated increased responsive behaviours. Resident #009's recent quarterly Resident Assessment Instrument (RAI), dated December 2015, revealed an increase to daily occurrences of responsive behaviour. A review of resident #009's progress notes, dated August 2015 to March 2016, indicated three incidents of responsive behaviour which included specific responsive behaviours.

The Inspector reviewed the care plan for resident #009, which did not indicate a focus of responsive behaviours, identify their triggers, or interventions that would promote resident safety and provision of care. The care plan was not updated with the current RAI assessment.

During an interview on March 2, 2016, with PSW #108, they reported that resident #009 displayed specific responsive behaviours.

PSW #108, confirmed to the Inspector that the kardex for resident #009 did not indicate that they exhibited specific responsive behaviours or provide clear direction for

interventions to keep them safe. [s. 6. (1) (c)]

2. The licensee has failed to ensure that residents #003, #008, #009 and #014 were reassessed and their plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

Inspector #621 reviewed the most recent care plan for resident #008 dated January 2016, found that under the Bladder Continence Care Program Foci which was last revised on September 2015, identified that resident #008 was on a scheduled toileting program. This program identified that the resident was to be toileted upon waking, at specific times and prior to bed.

During observations made by the Inspector during times the resident was scheduled to be toileted on March 1st and 2nd, 2016, no staff were observed to assist the resident to the toilet as per the care plan.

During an interview on March 3, 2016, with PSW #112, they reported to the Inspector that resident #008 required a urinary intervention, and was no longer on a scheduled toileting program for bladder management.

The Inspector interviewed RN #102, regarding the care plan for resident #008 and they stated that resident #008 was no longer toileted due to deterioration in continence. RN #102 confirmed that the care plan strategies which indicated that this resident was on a scheduled toileting program and to be toileted at specific times and prior to bed, did not reflect the resident's current care needs and that this would need to be removed from the care plan.

During an interview with the Director of Care (DOC), on March 3, 2016, they confirmed that expectations for documentation of changes to resident care needs would include updates to the resident's care plan. The DOC reviewed the care plan with the Inspector for resident #008 and acknowledged that the plan of care had not been revised to reflect this resident's current continence care needs and should have been. [s. 6. (10) (b)]

3. Inspector #621 reviewed the most recent care plan for resident #014 dated January 2016, found that under a Behaviour Section which was last revised on October 2014, identified that resident #014 was to have Dementia Observation System (DOS) charting completed every hour.

A review of the home's policy titled, "13.1 Management of Residents Exhibiting Complex, Difficult, and Responsive Behaviours", last revised August 2013, it was noted under procedure 5.0 that in the event that a resident presents with difficult to manage behaviours that behaviour documentation was to be initiated in the resident's record for a seven day period.

On March 2, 2016, the Inspector interviewed RPN #101 regarding the care plan for resident #014 and they stated that under a Behaviour Foci, this resident was identified to have required DOS charting every hour since October 2014. However, RPN #104 confirmed that they were not completing DOS charting unless the resident exhibited behaviour that required monitoring, and only for a week unless further incidents occurred before the last DOS was completed. RPN #104 reported to the Inspector that resident #014 had not exhibited behaviours consistently between August 2015, and March 2016, and did not have DOS charting completed on multiple dates from September 2015 to March 2016.

RPN #104 confirmed with the Inspector that the resident's care plan did not reflect this resident's current care needs and needed to be updated.

During an interview on March 3, 2016, with the Director of Care (DOC), they confirmed that expectations for documentation of changes to resident care needs would include updates to the care plan. The DOC stated that the plan of care had not been revised to reflect resident #014's current care needs relating to DOS charting for responsive behaviours and should have been. [s. 6. (10) (b)]

4. Inspector #617 reviewed resident #003's health care record which indicated worsening incontinence since November 2015.

The Inspector interviewed PSW #108, they reported that resident #003 used a urinary device during the day and required a urinary intervention at night. However, due to the recent decline in resident #003's health status, they were now incontinent, no longer used the urinary device, and required a urinary intervention during the day and night. PSW #108, stated that they now assisted resident #003 with continence.

Resident #003's care plan and kardex regarding continence care last updated on August 2015, instructed the PSW to ensure a urinary device was in place and assist with the urinary intervention during the night.

The Inspector interviewed PSW #108, who confirmed that the care plan was not updated to reflect the current care needs of the resident. [s. 6. (10) (b)]

5. On February 23, 2016, Inspector #617 observed resident #009 sitting in their wheelchair which was positioned in a specific manner and the safety device was not engaged. The Inspector reviewed resident #009's health care record which included consent and a physician's order for the use of a safety device up to January 2016, when the safety device was discontinued.

A review of resident #009's care plan and kardex revealed interventions for use of the safety device while resident #009 was in their wheelchair last updated on April 2015. The positioning of the wheelchair was not indicated in the plan of care.

During an interview on March 2, 2016, with PSW #108, they reported that resident #009 had the safety device discontinued in January and no longer used it when sitting in the wheelchair. PSW #108 reported that resident #009's wheelchair was to be positioned in a certain way during specific aspects of care.

The inspector interviewed PSW #108 who confirmed that the care plan was not updated to reflect the current care needs of the resident. PSW #108 stated that a staff member not familiar with resident #009 could inadvertently apply the safety device and risk injury to the resident due to the care plan not being updated. [s. 6. (10) (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 residents #003, #008, #009 and #014 are reassessed and the plans of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. As well, to ensure that there is a written plan of care for resident #009 that sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

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 the emergency plan for alternate measures for monitoring the building in the event of door security failure was complied with.

Inspector #613 reviewed a critical incident that identified that all magnetic locks on the exit doors were malfunctioning.

On March 2, 2016, the Administrator provided the Inspector with the home's emergency plan titled, "Alternate Measures for Monitoring Building in Event of Door Security Failure," which identified that the senior person on duty in each department would ensure that all areas in their department were monitored every 15 minutes with a full resident count, so that any missing resident would be quickly detected. The policy also dictated that staff were to keep records of their rounds.

During an interview on March 2, 2016, with RN #102, they reported to the Inspector that staff complete hourly resident counts and there was no record kept of the rounds.

During interviews on March 3, 2016, with PSW #118 and #119, they both reported to the Inspector that staff did not complete rounds at a specific time, rather staff observed the exit doors when they were in the hallways in between resident care. RPN #103 confirmed to the Inspector that no documentation was recorded of their rounds.

The Director of Care confirmed staff should be following the home's emergency plan. The DOC stated staff should be ensuring the interior door prior to exiting the outside exit door should be closed to deter residents from going towards the exit door. These interior doors were not consistently closed during the inspection. [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 the emergency plan for alternate measures for monitoring the building in the event of door security failure is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident (CI) report received by the Director which reported an incident of alleged abuse. A Critical Incident was submitted to the Director one business day after the alleged abuse had occurred.

During an interview on February 25, 2016, with the Administrator, they confirmed to Inspector #621 that CI was not reported immediately to the Director as per legislative requirements. [s. 24. (1)]

2. A Critical Incident (CI) report was submitted to the Director regarding neglect of resident #002, however the incident occurred one day earlier.

Inspector #617 reviewed the home's investigation which identified that resident #002 reported to the Director of Care in February 2015 that over the previous weekend in February 2015, they were not provided care for a prolonged period of time despite calling out for assistance and that PSW staff were negligent in providing care to them.

The Inspector reviewed the home's policy #3.2 titled, "Residents' Rights and Safety, Abuse and Neglect Prevention Program", last revised on June 2015, which indicated that any staff/volunteer witnessing or having knowledge of an alleged/actual act of abuse or becoming aware of one shall immediately report it to his/her immediate Manager, the Director or Care or the Administrator. The Administrator/Designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System, or via pager.

During an interview with the Director of Care, they confirmed that the report of the suspected neglect of resident #002 was reported late to the Director and they should have notified the Director immediately as it was an expectation of the home's policy.

3. A Critical Incident (CI) Report was submitted to the Director regarding abuse of resident #002, however the incident occurred nine days earlier.

Inspector #617 reviewed the home’s investigation which identified an email dated December 2015, sent to the Director of Care and the Administrator, from RN #102. The email was a report of PSW #120 allegedly abusing resident #002.

The Inspector reviewed the home's policy #3.2 titled, "Residents' Rights and Safety, Abuse and Neglect Prevention Program", last revised on June 2015, which indicated that any staff/volunteer witnessing or having knowledge of an alleged/actual act of abuse or becoming aware of one shall immediately report it to his/her immediate Manager, the Director or Care or the Administrator. The Administrator/Designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System, or via pager.

During an interview with the Director of Care, they confirmed that the home was aware of the alleged staff to resident abuse in December 2015 and it was reported late to the Director and they should have notified the Director immediately as it was an expectation of the home's policy. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of any resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to any resident, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of resident #003 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Inspector #617 reviewed resident #003's health care record which indicated worsening incontinence. Resident #003's quarterly Resident Assessment Instrument (RAI) dated November 2015, revealed the resident had declined in regards to continence.

The Inspector interviewed PSW #108 who reported that resident #003 became more incontinent and had declined in their ability to remain continent over the past four months.

The Inspector reviewed the home's policy section 12.1 titled, "Continence Care and Bowel Management Program", last revised on December 2015, which indicated that the registered staff were to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument:

-on admission
-quarterly
-after any change in condition that may affect bladder or bowel continence.

Resident #003's health care records were reviewed by the Inspector and a continence assessment was not found. On February 25, 2016, Interdisciplinary Team Member #107 and the Director of Care were interviewed by the Inspector who confirmed that resident #003 did not have a continence assessment completed when their condition changed. The Director of Care confirmed registered staff were to have completed the continence assessment for resident #003 and did not. [s. 51. (2) (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 resident #003 who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of resident #003 requires, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to review the meal and snack times with the Residents' Council.

Inspector #617 interviewed resident #017, President of the Residents' Council. They reported that the home had not reviewed the meal and snack times with the Residents' Council. The Inspector reviewed the minutes of the Residents' Council dated January 2016 and February 2016, and there was no reference/indication that the meal and snack time had been reviewed.

During an interview with the Administrator, they confirmed that the home was not aware they were required to review the meal and snack times with the Residents' Council and had not reviewed the times with them. [s. 73. (1) 2.]

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 they review the meal and snack times with the Residents' Council, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person hired as a Nutrition Manager after the coming into force of this section was an active member of the Canadian Society of Nutrition Management or a Registered Dietitian.

During an interview on February 25, 2016, with Acting Nutrition Manager #104, they identified to Inspector #621 that they had been working in the capacity of the home's Nutrition Manager for the past two months. The Acting Nutrition Manager #104 reported that they were qualified as a chef and held a food handler's certificate.

During a follow up meeting on February 25, 2016, with the Administrator, they confirmed that the home had been without a qualified Nutrition Manager since January 16, 2016 and that the Acting Nutrition Manager #104, did not hold membership with the Canadian Society of Nutrition Management, and was not licensed to practice as a Registered Dietitian. Consequently, the home did not have a person hired in the capacity of Nutrition Manager that met legislative requirements. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a Registered Dietitian, to be implemented voluntarily.

WN #8: 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 Family Council, in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview on March 1, 2016, with the President of Family Council, they reported to Inspector #621 that a copy of the home's annual satisfaction survey had not been provided to Family Council to date.

A review of the Family Council meeting minutes from December 2014, July 2015 and November 2015 did not identify business arising or agenda items that spoke to a review of the satisfaction survey. The President of Family Council verified that there were only three meetings of Family Council, since December 2014.

During an interview on February 25, 2016, with the Activity Coordinator #106, they reported that they support Family Council with preparation and follow up to business arising from the meetings. The Activity Coordinator #106 confirmed that the home had not sought the advice of the Family Council in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

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

During an interview on March 1, 2016 with the President of Family Council, they reported to Inspector #621 that results of the home's annual satisfaction survey had not been provided to Family Council to date.

A review of the Family Council meeting minutes from December 2014, July 2015 and November 2015 did not identify business arising or agenda items that spoke to a review of the satisfaction survey results for 2014 or 2015. The President of Family Council verified that there were only three meetings of Family Council since December 2014.

During an interview on February 25, 2016, with the Activity Coordinator #106, they reported that they support Family Council with preparation and follow up to business arising from the meetings. They confirmed that the home had not made the results of the annual satisfaction survey available to Family Council to seek their advice. [s. 85. (4) (a)]

3. The licensee failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council to seek their advice.

Inspector #617 interviewed resident #017, President of Residents' Council, who reported that the home had not presented to the Residents' Council the results of the satisfaction survey that were sent out to the residents and family to complete last year.

A review of Resident Council meeting minutes dated January 2016, and February 2016, did not identify business arising or agenda items that spoke to a review of the satisfaction survey results for 2015.

The Inspector interviewed the Administrator, who confirmed that the home had compiled the results of the satisfaction survey for 2015, but did not make them available to the Residents' Council and Family Council. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure they seek the advice of the Family Council, in developing and carrying out the satisfaction survey and acting on its results and the results of the survey are documented and made available to the Family Council and Residents' Council to seek their advice, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the results of the annual evaluation of the medication management system and any changes that were implemented.

During an interview on March 3, 2016, the Director of Care was unable to provide a written annual evaluation of the medication management system and they confirmed it had not been completed. [s. 116. (5)]

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 written record of the results of the annual evaluation of the medication management system is kept and any changes that were implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure a monthly audit was undertaken of the daily count sheet of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During an interview on March 2, 2016, with RN #102 and RPN #101, they both reported to Inspector #613 that they were unsure if monthly audits were completed on the narcotic control count sheets. RPN #101 showed the Inspector a binder containing the completed Narcotic Control Count sheets; however, there was no documentation to identify that monthly audits were completed.

During an interview on March 3, 2016 with the Director of Care (DOC), they informed the Inspector that they complete the monthly audits of the narcotic control sheets.

The Inspector asked the DOC to show the completed monthly audits. The DOC was only able to show the Inspector the completed audits for January 2016. There were no audits completed prior to this date. The DOC confirmed that the January 2016 monthly audit was the only audit that had been completed. [s. 130. 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 a monthly audit is undertaken of the daily count sheet of controlled substances to determine if there is any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #11: 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 improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents were communicated to the Residents' Council, on an ongoing basis.

During an interview with resident #017, President of the Residents' Council, they reported to Inspector #617 that the home did not present quality improvements made to the home on an ongoing basis. A review of the minutes from Resident Council Meetings held January 2016, and February 2016, did not indicate presentation of home improvements for the quality program.

During an interview with the Administrator, they confirmed that the home had not presented their quality improvements made to accommodation, care, services, programs and goods provided to the Residents' Council. [s. 228. 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 that 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, on an ongoing basis, to be implemented voluntarily.

WN #12: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the following immunization and screening measures were in place:

Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Inspector #617 reviewed the home's policy titled, "Vaccines - #11.1" last revised on March 2015, which indicated that all residents admitted to the facility would be assessed upon admission for their pneumococcal status and if unimmunized, immunization would be administered in keeping with the standard procedure for immunization. The policy also indicated that Tetanus and diptheria immunization were recommended for all residents and that they should be immunized.

A review of resident #018's health care record identified a completed admission checklist for resident #018. The admission checklist indicated that an assessment of resident #018's pneumovax vaccine and tetanus and diphtheria immunization status was to be documented. However, that documentation was not on the admission checklist.

During an interview with the Director of Care, they confirmed that it was the home's expectation of the registered staff to assess each resident for their immunization status of pneumococcal and tetanus and diptheria vaccinations on admission and offer the vaccination if eligible and consented. The Director of Care confirmed that resident #018's immunization was not offered on admission and should have been. [s. 229. (10) 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 that all residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an environmental hazard that affected the safety security or well-being of one or more residents for a period greater than six hours including, failure of the security system related to the magnetic locks malfunctioning, no later than one business day after the occurrence of the incident.

Inspector #613 reviewed critical incident that identified all magnetic locks on the exit doors were malfunctioning.

The critical incident occurred on January 21, 2016 and was not reported to the Director until February 25, 2016.

During an interview on March 3, 2016, with the Director of Care, they confirmed that the critical incident was submitted late to the Director and was not reported no later than one business day after the occurrence of the incident as per legislative requirements. [s. 107. (3) 2. i.]

2. The licensee failed to ensure that the Director was informed in writing whether a family member, person of importance or a substitute decision-maker of resident #016 was contacted to notify them of the incident involving the resident.

Inspector #613 reviewed critical incident that identified that resident #016 had a fall in August 2014 and sustained an injury. Resident #016 was transferred to hospital and received medical treatment.

The Inspector reviewed the critical incident report and completed a health care record review and could not locate documentation to identify whether resident #016's substitute decision maker had been notified of the incident involving the resident.

During an interview with the Administrator, they confirmed that if it was not documented in the e-notes on Point Click Care then the registered staff did not notify the substitute decision maker. The Administrator stated staff should have notified the substitute decision maker as it is an expectation of the home's policy.

The Inspector reviewed the home's policy titled, "Falls Prevention Program" that identified post fall management, the interdisciplinary team will notify the substitute decision maker about the fall. [s. 107. (4) 3. iv.]

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

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Issued on this 27th day of May, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), JULIE KUORIKOSKI (621), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_395613_0003
Log No. / Registre no:	001648-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 19, 2016
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall

a) Ensure all the doors leading to non residential areas are equipped with properly working locks to restrict unsupervised access to those areas by residents.

b) Repair the magnetic locks on all the exit doors to ensure resident safety.

c) Ensure all exit doors are kept closed and locked at all times.

d) When the magnetic locks are not functioning, ensure staff is following the home's emergency plan by monitoring the residents every 15 minutes with a full resident count and records kept of the rounds.

e) Complete on-going daily audits of all exit doors to ensure closed and locked and maintain records.

f) Ensure training and retraining of staff includes education of the home's door security policies and procedures and emergency plan in the event of door security failure and the home's responsibility for maintaining a safe and secure environment for the residents at all times.

Grounds / Motifs :

1. The licensee failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident were kept closed and locked.

During the initial tour of the home on February 22, 2016, Inspector #613 was able to open eight exit doors that led to outdoor non-residential areas. All of the exit doors led to a parking lot that surrounded the home. The alarm sounded when the Inspector opened each unlocked door.

During an interview, Maintenance #111 informed the Inspector that there was a problem with the magnetic locks. Maintenance #111 also stated that they had been aware of the issue since it occurred on January 21, 2016.

During an interview on February 22, 2016, with the Administrator, they informed the Inspector that they were not aware of the problems with the exit doors not locking.

During an interview, RN #102 informed the Inspector that all staff were aware that the magnetic locks on the exit doors were not working. RN #102 also stated that the alarm would still sound and alert staff if any of the doors were opened but, the doors would not remain locked. RN #102 informed the Inspector to ensure resident safety, personal support workers and registered staff were conducting hourly checks of the doors and head counts of all the residents.

During an interview on February 25, 2016, with Maintenance Supervisor #110, they reported to the Inspector that the company to repair the doors would be in the home on Friday February 26, 2016.

During an observation on March 1, 2016, the Inspector noted that two doors in were repaired; however, the remaining six doors in the home were not repaired. Maintenance #111 reported to the Inspector that the company was supposed to be back to the home on March 1, 2016 to repair the remaining doors but, they did not show. As reported by Maintenance #111, the company still needed to figure out where the short in the magnetic box was occurring in order to ensure all doors remained locked.

During an interview on March 3, 2016, with the Director of Care (DOC), they reported to the Inspector that they were unsure what the home had done to repair the magnetic lock malfunction on all of the exit doors. The Maintenance Supervisor had been off work. The home was unable to provide the Inspector with a log or tracking record to identify what they had done to repair the magnetic lock malfunctioning on the doors since January 21, 2016. The DOC confirmed that the magnetic lock malfunction had been an issue since January 21, 2016.

The scope of this issue was a pattern of the home doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident were not kept closed and locked. There was no previous non compliance issued related to this; however, the severity was determined to be potential for actual harm or risk to the health, safety and well-being of the residents of the home. (613)

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 : Jun 03, 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 soins 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 soins 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 19th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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