Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2019	2018_787640_0027 (A1)	014280-17, 018005-18	Complaint

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

St. Andrew's Terrace Long Term Care Community
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

Amended by HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

Changes made at the request of the Administrator.

Issued on this 12nd day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended by HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 17, 18, 19, 20, 21, 27, 28, 2018 and January 2, 3, 4, 7 and 8, 2019.

This inspection was conducted with a Critical Incident inspection

The following complaint reports were inspected;

Log #014280-18 related to medication regime, responsive behaviour management, plan of care

Log #018005-18 related to unknown cause of fracture, delayed treatment of fracture

PLEASE NOTE: Written Notification and Compliance Order related to O. Reg. 79/10, s. 8 (1) and s. 50 (2) (b) (iii) identified in a concurrent inspection #2018_787640_0028 (Log #006722-18, Log #012215-18 and Log #030172-18)

During the course of the inspection the LTCH Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedures and conducted interviews.

During the course of the inspection, the inspector(s) spoke with residents, family, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Manager of Food Services (MFS), Registered Dietitian (RD), Resident Care Coordinators (RCC), Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Behaviour Support Ontario (BSO) staff, Resident Care Coordinator - Quality and Education, Manager of Resident Care (MRC) and the Administrator.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On June 20, 2018, resident #001 had an altercation with a male resident resulting in resident #001 becoming unbalanced. They fell backward to the floor while the male resident held their forearms.

On an identified date in July 2018, altered skin integrity was observed. On an identified date in July 2018, the resident was sent to a higher level of care for assessment and treatment.

The Long-Term Care Homes (LTCH) Inspector reviewed resident #001's clinical record which did not include a post-fall assessment using a clinically appropriate assessment instrument.

The Manager of Resident Care (MRC) acknowledged that a post-fall assessment, using a clinically appropriate assessment instrument specifically designed for falls, had not been completed related to this resident being pushed to the floor in June 2018.

The licensee failed to ensure that resident #001 was assessed using a clinically appropriate assessment instrument following their fall in June 2018. [s. 49. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, the licensee was required to ensure that the policy, protocol or procedure was complied with.

i) In accordance with O. Reg. 79/10, s.68 that required the licensee to ensure that the interdisciplinary program of nutrition care and hydration programs, were developed and implemented in the home to include relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy "Food and Fluid Tracking" that directed staff to review fluid intake daily and where a decrease in fluid consumption occurred, a dehydration assessment was to be completed and a referral sent to the dietary department, and that the Manager of Food Services

(MFS) was to immediately initiate the increased fluid intervention.

The LTCH Inspector reviewed resident #002's dietary records in relation to a complaint, log #014280-17.

Resident #002 was transferred to a higher level of care on an identified date in July 2017 for related treatment.

The LTCH Inspector reviewed the clinical record that identified 12 occasions, during a 16 day look back period that resident #002 had altered dietary consumption. The Registered Dietitian (RD) assessed the resident to require a specific amount of fluid intake per day. The resident's plan of care directed staff that the resident needed to consume a specific amount of fluid per day.

The Manager of Resident Care (MRC) told the LTCH Inspector that it was expected that staff review fluid intake daily and where a consecutive three day intake was less than a specific amount, a dehydration assessment was to be completed and a referral sent to the dietary department. On an identified date in June 2017, the food and fluid intake report noted there had been three consecutive days of intake below the identified amount.

The dehydration assessment completed on an identified date in June 2017, indicated decreased fluid intake. The dietary follow up to this dehydration assessment referral occurred two days later. Initiation of immediate increased fluid intervention was not implemented as per the policy.

The MRC acknowledged the home failed to ensure that staff complied with their policy regarding the assessments, referrals and actions required for decreased fluid intake and signs of dehydration.

ii) In accordance with O. Reg. 79/10 s.48, that required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home to include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the licensee's policy "Fall Prevention Program" that directed staff to continue to monitor the resident post fall based on the resident's condition; Fall without apparent injury required: Vital signs and a progress note to be completed each shift for 24 hours summarizing the residents

condition as a result of the fall.

a) Resident #001 was pushed to the floor by another resident in an altercation that occurred in June 2018. Resident #001 fell backward as a result.

The LTCH Inspector reviewed resident #001's clinical record which did not include the required 24 hour shift post fall assessment progress notes or vital signs.

The Fall Prevention Program Lead acknowledged that the required progress notes and vital signs for 24 hours following resident #001's fall were not completed as per the home's policy.

b) The LTCH Inspector reviewed resident #014's clinical record which did not include the required 24 hour shift progress notes or vital signs following their fall in April 2018.

The Fall Prevention Program Lead acknowledged that the required progress notes and vital signs for 24 hours for resident #014 were not completed as per the home's policy.

The licensee failed to ensure that the home's Fall Prevention Program policy was complied with.

iii) In accordance with O. Reg. 79/10, s. 29, that required the licensee to ensure that the interdisciplinary programs including minimizing of restraints, were developed and implemented in the home, included a written policy and must meet the requirements as set out in section 109.

Specifically, staff did not comply with the home's policy "Personal Assistance Safety Devices" that directed that the care plan must include a description of the device that was being authorized and instructions on when and how it was to be used. The plan of care must state the purpose of the PASD and how it was supporting the resident's ADLs, how the PASD was to be used, when and who was to apply and remove, the frequency of monitoring and the specific risks associated.

a) Resident #005 had two PASDs in place.

Resident #005's plan of care included the use of one of the PASDs when in bed

and did not include the purpose of the device or how they supported ADLs for the resident.

The use of the second PASD was implemented in 2014, was not included in the plan of care to include a description of the device, instructions on when and how it was to be used and the purpose of the PASD. The plan of care did not include how this PASD supported ADLs for resident #005.

b) Resident #009 had two PASDs in place.

Their plan of care did not include the use of one of the PASDs.

The second PASD was included in the plan of care with no description on when and how to use them, the purpose of the PASD and how they supported the resident's ADLs. There were no directions related to frequency of monitoring and the specific risks associated with their use. The plan of care did not included the specific risks associated with the use of the PASD.

c) Resident #010 had two PASDs in place.

Their plan of care did not include the use of one of the PASDs, its purpose, and how it was supporting the resident's ADLs, how the PASD was to be used, when and who was to apply and remove, the frequency of monitoring and the specific risks associated with the use of the PASD.

The MRC acknowledged the home did not comply with their policy for Personal Assistance Safety Devices (PASD) related to the plans of care for residents #005. #009 and #010.

iv) In accordance with O. Reg. 79/10, s.114, that required the licensee to ensure that an interdisciplinary medication management program, was developed and implemented in the home and must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the home's policy "Oxygen Care" that directed staff to document oxygen therapy once each shift in the electronic Medication Administration Record (eMAR) and was to be set up as an every shift

oxygen eMAR prompt. The purpose was to verify that the flow rate setting was correct and the tank supply was sufficient.

The LTCH Inspector reviewed a Critical Incident Report related to oxygen treatment for resident #003.

Resident #003 required ongoing specific treatment related to their condition.

On an identified date in July 2017, during a specific shift, resident #003 was found in their room, in an altered condition. When staff assessed the situation, they found the resident had a specific piece of equipment in place but the required and associated treatment was not available.

The LTCH Inspector reviewed the resident's clinical record to include the eMAR which directed staff to apply the specific treatment and to ensure the treatment was available on two shifts. There was no direction for one specific shift to perform the task.

During an interview with RPN #102, they told the LTCH Inspector that it was an expectation and a practice that all shifts check that the treatment was available on all three shifts.

The Manager of Resident Care (MRC) acknowledged that staff did not include the task of checking that the specific treatment was available on all shifts as per the home's policy.

The licensee failed to ensure that the home's Oxygen Care policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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. 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 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Resident #001returned to the home on an identified date in July 2018, with altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include any skin and wound assessments of the altered skin integrity.

The Skin and Wound Lead for the home told the LTCH Inspector that the altered skin integrity was expected to be assessed using the home's clinically appropriate skin assessment.

b) Resident #011 sustained two areas of altered skin integrity as a result of an altercation with another resident.

The LTCH Inspector reviewed the clinical record which did not contain an initial skin assessment using a clinically appropriate assessment instrument.

RPN #117 acknowledged there was no initial skin assessment completed of either area of altered skin integrity for resident #011.

The Skin and Wound Lead acknowledged there were no assessments completed using the clinically appropriate skin assessment for residents #001 and #011 related to their specific altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

a) Resident #001 had a treatment at a higher level of care and returned to the home in July 2018, with an area of altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include a referral to the RD or an assessment by an RD related to the altered skin integrity.

The RD told the LTCH Inspector they documented by exception, and they were not aware of the specific area of altered skin integrity. They would not document this information unless there was a concern.

The home's policy "Resident Chart - Documentation in PCC Progress Notes" directed that all disciplines contributing to the record are to document the event, action or assessment in an accurate, true and honest manner.

The Skin and Wound Program Lead told the LTCH Inspector that it was expected that a referral to and an assessment by the RD be completed related to the specific altered skin integrity for resident #001. They acknowledged the RD did not assess the resident related to the specific altered skin integrity.

b) Resident #009 fell and sustained an injury that required a higher level of care and treatment. They returned to the home on an identified date in June 2018, with five areas of altered skin integrity.

During a review of the clinical record, the initial skin assessment identified there to be four areas of altered skin integrity.

On an identified date in June 2018, staff referred the resident to the RD related to re-admission from hospital and multiple areas of altered skin integrity. The RD documented that the referral was received; then noted the four areas of altered skin integrity that were listed in the referral note. The documentation then read the RD aware and will monitor. Please advise RD if there are concerns.

The clinical record did not include the assessment documentation from the RD related to the referral.

The RD acknowledged they had not documented an assessment of the re-admission and altered skin integrity related to the referral.

c) On an identified date in November 2018, resident #005 was assessed to have altered skin integrity.

On an identified date in November 2018, staff referred the resident to the RD related to the altered skin integrity.

The clinical record was reviewed by the LTCH Inspector and the RD documented on an identified date in November 2018, that the referral was received re altered skin integrity. RD aware and will monitor. No changes to the current interventions. Please refer as needed.

The licensee failed to ensure that residents #001, #005 and #009 were assessed by the RD related to their altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident who exhibited 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.

a) Resident #001 had a treatment for an injury at a higher level of care and they returned to the home on an identified date in July 2018 with altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include any weekly skin and wound assessments of the altered skin integrity.

The Skin and Wound Lead for the home told the LTCH Inspector that the altered skin integrity was expected to have weekly skin and wound assessments completed.

The Skin and Wound Lead acknowledged there were no weekly skin and wound assessments completed of the specific altered skin integrity.

b) Resident #009 fell and required higher level of care and treatment. They returned to the home on an identified date in June 2018, with a specific area of altered skin integrity.

RPN #109 told the LTCH Inspector that when a resident had any areas of altered skin integrity, staff completed a weekly assessment of the altered skin integrity and documented same in the progress notes until the area (s) had healed.

The LTCH Inspector reviewed resident #009's clinical record which did not include weekly skin assessments related to the specific altered skin integrity.

The licensee failed to ensure that resident's #001 and #009's altered skin integrity were assessed weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #001 had a treatment at a higher level of care facility and they returned to the home on an identified date in July 2018, with specific altered skin integrity.

The LTCH Inspector reviewed the resident's plan of care and found no revisions related to the management and care of the specific altered skin integrity, potential for pain, potential for complications, potential for altered sleep /rest patterns and potential for further concerns related to the specific altered skin integrity.

The Resident Care Coordinator (RCC) for Quality and Education acknowledged that the resident's plan of care was not reviewed and revised when the resident's care needs changed as a result of the treatment received.

The licensee failed to ensure the resident's plan of care was reviewed and revised when their care needs changed. [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 that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written record kept relating to the annual evaluation of the dietary services and hydration program included the date that those changes were implemented.

The LTCH Inspector reviewed the home's "Food Service Department Annual Department Evaluation" dated January 3, 2018.

The evaluation did not identify the date that changes to the program were implemented.

The MFS acknowledged the dates the changes to the program were implemented were not included in the written record of the annual review of the Food Services Program.

The licensee failed to ensure the dates of changes to the food service program were included in the the written record of the annual evaluation of the program. [s. 30. (1) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff received annual training in a) skin and wound program and b) fall prevention program as required under subsection 76 (7) of the Act.

a) The LTCH Inspector reviewed the required skin and wound program training and education provided to direct care staff. Five percent of direct care staff did not participate in the required skin and wound program training and education for the current year.

b) The LTCH Inspector reviewed the required fall prevention program training and education provided to direct care staff. Four percent of direct care staff did not participate in the required fall prevention program training and education for the current year.

The licensee failed to ensure that all direct care staff received annual training related to skin and wound and fall prevention programs. [s. 221. (2) 1.]

Issued on this 12nd day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by HEATHER PRESTON (640) - (A1)
Inspection No. / No de l'inspection :	2018_787640_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014280-17, 018005-18 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 12, 2019(A1)
Licensee / Titulaire de permis :	Steeves & Rozema Enterprises Limited 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	St. Andrew's Terrace Long Term Care Community 255 St. Andrew's Street, CAMBRIDGE, ON, N1S-1P1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mark Van Dyke

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Steeves & Rozema Enterprises 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. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49 (2) of O. Reg. 79/10.

Specifically, the licensee must ensure that resident #001 and any other resident who has fallen is assessed post-fall using a clinically appropriate assessment instrument specifically designed for falls.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On June 20, 2018, resident #001 had an altercation with a male resident resulting in resident #001 becoming unbalanced. They fell backward to the floor while the male resident held their forearms.

On July 7, 2018, the resident's SDM expressed concern to staff about bruising on resident #001's right upper arm and that they were in pain.

On July 10, 2018, the resident's SDM expressed concern again to the registered staff on duty, about the bruising on the upper right arm that was increasing in size and the resident's pain. The SDM had requested an x-ray be taken.

On July 13, 2018, the resident was sent to the ER at the request of the SDM, due to the bruising increasing in size and increased pain with movement of the arm. An x-ray was taken which identified a right proximal humerus posterior fracture dislocation. The SDM told the LTCH Inspector the orthopaedic surgeon had stated that this type of fracture was often caused by a fall backward from a standing position.

On July 14 2018, the resident underwent an open reduction and internal fixation of the proximal right humerus, with the use of a plate and bone substitute allograft and right proximal biceps tenodesis.

The Long-Term Care Homes (LTCH) Inspector reviewed resident #001's clinical record which did not include a post-fall assessment using a clinically appropriate assessment instrument.

The Manager of Resident Care (MRC) acknowledged that a post-fall assessment, using a clinically appropriate assessment instrument specifically designed for falls, had not been completed related to this resident being pushed to the floor on June 20, 2018.

The licensee failed to ensure that resident #001 was assessed using a clinically appropriate assessment instrument following their fall on June 20, 2018.

The severity of this issue was determined to be a level 3, actual harm/risk. The scope of the issue was a level 1, isolated. The home had a level 2 compliance history of one or more unrelated non-compliance in the last three years. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of O. Reg. 79/10.

Specifically, the licensee must ensure that;
a) the home's policy "Food and Fluid Tracking' and the procedures identified within the policy related to dehydration assessments and referrals are complied with,
b) the home's policy "Fall Prevention Program" and the procedures identified within the policy related to assessment of residents post fall are complied with,
c) the home's policy "Oxygen Care" is complied and,
d) the home's policy "Personal Assistance Safety Devices", is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, the licensee was required to ensure that the policy, protocol or procedure was complied with.

i) In accordance with O. Reg. 79/10, s.68 that required the licensee to ensure that the interdisciplinary program of nutrition care and hydration programs, were developed and implemented in the home to include relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee's policy "Food and Fluid Tracking" that directed staff to review fluid intake daily and where a decrease in fluid consumption occurred, a dehydration assessment was to be completed and a referral sent to the dietary department, and that the Manager of Food Services (MFS) was to immediately initiate the increased fluid intervention.

The LTCH Inspector reviewed resident #002's dietary records in relation to a complaint, log #014280-17.

Resident #002 was transferred to a higher level of care on an identified date in July 2017 for related treatment.

The LTCH Inspector reviewed the clinical record that identified 12 occasions, during a 16 day look back period that resident #002 had altered dietary consumption. The Registered Dietitian (RD) assessed the resident to require a specific amount of fluid intake per day. The resident's plan of care directed staff that the resident needed to consume a specific amount of fluid per day.

The Manager of Resident Care (MRC) told the LTCH Inspector that it was expected that staff review fluid intake daily and where a consecutive three day intake was less than a specific amount, a dehydration assessment was to be completed and a referral sent to the dietary department. On an identified date in June 2017, the food and fluid intake report noted there had been three consecutive days of intake below the identified amount.

The dehydration assessment completed on an identified date in June 2017, indicated decreased fluid intake. The dietary follow up to this dehydration assessment referral occurred two days later. Initiation of immediate increased fluid intervention was not implemented as per the policy.

The MRC acknowledged the home failed to ensure that staff complied with their policy regarding the assessments, referrals and actions required for decreased fluid intake and signs of dehydration.

ii) In accordance with O. Reg. 79/10 s.48, that required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and

implemented in the home to include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the licensee's policy "Fall Prevention Program" that directed staff to continue to monitor the resident post fall based on the resident's condition; Fall without apparent injury required: Vital signs and a progress note to be completed each shift for 24 hours summarizing the residents condition as a result of the fall.

a) Resident #001 was pushed to the floor by another resident in an altercation that occurred in June 2018. Resident #001 fell backward as a result.

The LTCH Inspector reviewed resident #001's clinical record which did not include the required 24 hour shift post fall assessment progress notes or vital signs.

The Fall Prevention Program Lead acknowledged that the required progress notes and vital signs for 24 hours following resident #001's fall were not completed as per the home's policy.

b) The LTCH Inspector reviewed resident #014's clinical record which did not include the required 24 hour shift progress notes or vital signs following their fall in April 2018.

The Fall Prevention Program Lead acknowledged that the required progress notes and vital signs for 24 hours for resident #014 were not completed as per the home's policy.

The licensee failed to ensure that the home's Fall Prevention Program policy was complied with.

iii) In accordance with O. Reg. 79/10, s. 29, that required the licensee to ensure that the interdisciplinary programs including minimizing of restraints, were developed and implemented in the home, included a written policy and must meet the requirements as set out in section 109.

Specifically, staff did not comply with the home's policy "Personal Assistance Safety Devices" that directed that the care plan must include a description of the device that

was being authorized and instructions on when and how it was to be used. The plan of care must state the purpose of the PASD and how it was supporting the resident's ADLs, how the PASD was to be used, when and who was to apply and remove, the frequency of monitoring and the specific risks associated.

a) Resident #005 had two PASDs in place.

Resident #005's plan of care included the use of one of the PASDs when in bed and did not include the purpose of the device or how they supported ADLs for the resident.

The use of the second PASD was implemented in 2014, was not included in the plan of care to include a description of the device, instructions on when and how it was to be used and the purpose of the PASD. The plan of care did not include how this PASD supported ADLs for resident #005.

b) Resident #009 had two PASDs in place.

Their plan of care did not include the use of one of the PASDs.

The second PASD was included in the plan of care with no description on when and how to use them, the purpose of the PASD and how they supported the resident's ADLs. There were no directions related to frequency of monitoring and the specific risks associated with their use. The plan of care did not included the specific risks associated with the use of the PASD.

c) Resident #010 had two PASDs in place.

Their plan of care did not include the use of one of the PASDs, its purpose, and how it was supporting the resident's ADLs, how the PASD was to be used, when and who was to apply and remove, the frequency of monitoring and the specific risks associated with the use of the PASD.

The MRC acknowledged the home did not comply with their policy for Personal Assistance Safety Devices (PASD) related to the plans of care for residents #005. #009 and #010.

iv) In accordance with O. Reg. 79/10, s.114, that required the licensee to ensure that an interdisciplinary medication management program, was developed and implemented in the home and must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the home's policy "Oxygen Care" that directed staff to document oxygen therapy once each shift in the electronic Medication Administration Record (eMAR) and was to be set up as an every shift oxygen eMAR prompt. The purpose was to verify that the flow rate setting was correct and the tank supply was sufficient.

The LTCH Inspector reviewed a Critical Incident Report related to oxygen treatment for resident #003.

Resident #003 required ongoing specific treatment related to their condition.

On an identified date in July 2017, during a specific shift, resident #003 was found in their room, in an altered condition. When staff assessed the situation, they found the resident had a specific piece of equipment in place but the required and associated treatment was not available.

The LTCH Inspector reviewed the resident's clinical record to include the eMAR which directed staff to apply the specific treatment and to ensure the treatment was available on two shifts. There was no direction for one specific shift to perform the task.

During an interview with RPN #102, they told the LTCH Inspector that it was an expectation and a practice that all shifts check that the treatment was available on all three shifts.

The Manager of Resident Care (MRC) acknowledged that staff did not include the task of checking that the specific treatment was available on all shifts as per the home's policy.

The licensee failed to ensure that the home's Oxygen Care policy was complied with.

The severity of this issue was determined to be a level 3, actual harm/risk. The scope of the issue was 2, pattern. The home had a level 3 compliance history of one or more related non-compliance in the last three full years with this section of O. Reg. 79/10 that included;
- written notification (WN) issued February 1, 2018 (2017_532590_0019) (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee must be compliant with s. 50 (2), specifically,

a) Residents #005 and #009 and any other residents, must have an RD assessment completed and documented related to altered skin integrity and,
b) Residents #001 and #009 and any other residents, must have weekly skin assessments for altered skin integrity by a member of the registered staff.

Grounds / Motifs :

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

a) Resident #001returned to the home on an identified date in July 2018, with altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include any skin and wound assessments of the altered skin integrity.

The Skin and Wound Lead for the home told the LTCH Inspector that the altered skin integrity was expected to be assessed using the home's clinically appropriate skin assessment.

b) Resident #011 sustained two areas of altered skin integrity as a result of an altercation with another resident.

The LTCH Inspector reviewed the clinical record which did not contain an initial skin assessment using a clinically appropriate assessment instrument.

RPN #117 acknowledged there was no initial skin assessment completed of either area of altered skin integrity for resident #011.

The Skin and Wound Lead acknowledged there were no assessments completed using the clinically appropriate skin assessment for residents #001 and #011 related to their specific altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

a) Resident #001 had a treatment at a higher level of care and returned to the home in July 2018, with an area of altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include a referral to the RD or an assessment by an RD related to the altered skin integrity.

The RD told the LTCH Inspector they documented by exception, and they were not aware of the specific area of altered skin integrity. They would not document this information unless there was a concern.

The home's policy "Resident Chart - Documentation in PCC Progress Notes", policy #RCM 09-01 with a revised date of August 1, 2016, directed that all disciplines contributing to the record are to document the event, action or assessment in an accurate, true and honest manner.

The Skin and Wound Program Lead told the LTCH Inspector that it was expected that a referral to and an assessment by the RD be completed related to the specific altered skin integrity for resident #001. They acknowledged the RD did not assess the resident related to the specific altered skin integrity.

b) Resident #009 fell and sustained an injury that required a higher level of care and treatment. They returned to the home on an identified date in June 2018, with five areas of altered skin integrity.

During a review of the clinical record, the initial skin assessment identified there to be four areas of altered skin integrity.

On an identified date in June 2018, staff referred the resident to the RD related to re-admission from hospital and multiple areas of altered skin integrity. The RD documented that the referral was received; then noted the four areas of altered skin integrity that were listed in the referral note. The documentation then read the RD

aware and will monitor. Please advise RD if there are concerns.

The clinical record did not include the assessment documentation from the RD related to the referral.

The RD acknowledged they had not documented an assessment of the re-admission and altered skin integrity related to the referral.

c) On an identified date in November 2018, resident #005 was assessed to have altered skin integrity.

On an identified date in November 2018, staff referred the resident to the RD related to the altered skin integrity.

The clinical record was reviewed by the LTCH Inspector and the RD documented on an identified date in November 2018, that the referral was received re altered skin integrity. RD aware and will monitor. No changes to the current interventions. Please refer as needed.

The licensee failed to ensure that residents #001, #005 and #009 were assessed by the RD related to their altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident who exhibited 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.

a) Resident #001 had a treatment for an injury at a higher level of care and they returned to the home on an identified date in July 2018 with altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record which did not include any weekly skin and wound assessments of the altered skin integrity.

The Skin and Wound Lead for the home told the LTCH Inspector that the altered skin integrity was expected to have weekly skin and wound assessments completed.

The Skin and Wound Lead acknowledged there were no weekly skin and wound assessments completed of the specific altered skin integrity.

b) Resident #009 fell and required higher level of care and treatment. They returned to the home on an identified date in June 2018, with a specific area of altered skin integrity.

RPN #109 told the LTCH Inspector that when a resident had any areas of altered skin integrity, staff completed a weekly assessment of the altered skin integrity and documented same in the progress notes until the area (s) had healed.

The LTCH Inspector reviewed resident #009's clinical record which did not include weekly skin assessments related to the specific altered skin integrity.

The licensee failed to ensure that resident's #001 and #009's altered skin integrity were assessed weekly.

This severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 2, pattern. The home had a level 2 compliance history of previous unrelated non-compliance in the past three full years.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by HEATHER PRESTON (640) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Central West Service Area Office