Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 22, 2015	2015_360111_0011	O-001963-15	Resident Quality Inspection

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

LYNDA BROWN (111), KARYN WOOD (601), MARIA FRANCIS-ALLEN (552), RENA BOWEN (549)

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): May 4-8, 11-14, 2015

The following inspections were completed concurrently during this inspection: follow-up log# O-001875015; critical incidents log # O-001703-15, O-001775-15, O-001824-15, O-001825-15, O-001923-15, O-002025-15 & O-002056-15; and complaints log # O-001842-15 & O-001727-15.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Administrator, Unit Managers, Manager of Quality and Education,Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW),Physiotherapist, Housekeeping staff, Co-ordinator of Resident and Family Services, Resident and Family Council, toured the home, reviewed resident health records, observed dining services, observed medication administration, reviewed resident and family council meeting minutes, review policies related to prevention of abuse and neglect, restraints, and falls prevention.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
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
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **2 VPC(s)**
- **2 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. 6. (7)	CO #001	2015_360111_0003	552

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are not charged for goods and services that the licensee is required to provide to residents under any agreement

between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Related to log# 001875:

Review of the health record of Resident #53 & #54 indicated the residents were noted to have restraint covers in use.

Inspector #601 observed Resident #54 on a specified unit sitting in a mobility device with a restraint and restraint cover in place.

Inspector #601 interviewed Staff #124 who indicated that families are notified by the registered staff when a resident requires a restraint cover as "an added restraint". The staff member indicated the registered staff will notify Motion Specialties after obtaining consent from families to purchase the restraint covers. The staff member was not sure of the cost involved.

Inspector #549 observed Resident #57 and #58 on a specified unit in the dining room with a restraint in place and restraint cover in place.

Inspector #549 interviewed Staff #122 who stated Resident #53 also had a seat belt cover "but it was lost some time ago". Staff #122 stated that Resident #53 no longer uses the restraint cover. Staff #122 stated "when a resident is assessed and requires a restraint cover, the nursing staff will contact the resident’s POA and obtain consent to use the restraint cover. Motion Specialties is then contacted by the home to provide the restraint cover. A charge for the restraint cover is then submitted to the resident’s POA".

Interview of Staff #123 by Inspector #111 on a specified unit indicated Resident #55 & #56 used restraint covers and they were used to prevent the resident's from removing the restraints. The Staff indicated the families are contacted for permission to order the restraint cover as there is a $25.00 charge by "Motion Specialties", who then send the family the bill. The staff member indicated Resident #55 no longer uses the cover as it had been lost. The staff member indicated that Resident #56 still uses the restraint cover.

Observation by Inspector #111 of Resident #55 indicated no restraint cover was in place. Observation of Resident #56 indicated no restraint cover was in use despite the restraint in use. The restraint cover was located int he resident's bathroom.

Interview of the Administrator indicated no knowledge of use of restraint covers in the home and had no knowledge of families being charged for the restraint covers.

The scope of the issue was that the use of restraint covers was widespread as they were being used throughout the home and the practice of charging for non-allowable charges (safety devices) has been ongoing. [s. 245. 3.]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's "Abuse and Neglect (Resident)-Zero Tolerance" (policy #14-18) reviewed March 2015, states the following on Page 8, Section B, Number 3: All those who witness or have knowledge of reasonable grounds for suspicion of abuse are required to report it to a supervisor or manager immediately in accordance with Section 24(1) of the LTCHA. The policy also indicated on page 10 of 15, under #2."Responsibility of Employees who witness or suspect alleged abuse or neglect to" report any witnessed, suspected, or alleged abuse to a supervisor or manager immediately.ON page 14 of 18 indicated "anyone failing to report witnesses or suspected abuse is in contravention of the requirements of MOHLTC and St. Josephs' of Fleming requirements.

Related to log #001824 & #001842:

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of staff to resident neglect that occurred over a two period. The CIR indicated the allegation was related to several resident being neglected by Staff #107, the allegation was reported the same day as the submission of the CIR, but the incidents occurred 10 days before it was reported. A complaint was also received regarding this incident.

Review of the home's investigation into the allegation of staff to resident neglect indicated the incidents of neglect of care occurred over a two day period by Staff #107. Six staff (which included Staff #118 & #119) had knowledge of the staff to resident neglect by Staff #107 and did not immediately report the neglect. Staff #107 no longer works in the home.

Interview of the 2 Unit Managers indicated "very concerned that staff were aware and did not immediately report".

Interview of Staff #118 & #119 identified receiving annual prevention of abuse and neglect training which included their reporting requirements, and were aware of what constituted neglect.

The home did not comply with the home's "Abuse and Neglect (Resident)-Zero Tolerance" as 6 staff had reasonable grounds to suspect staff to resident neglect and did not immediately report. [s. 20. (1)]

2. Related to Log #001825:

A Critical Incident Report was submitted to the Director on a specified date indicating a suspected staff to resident physical abuse towards Resident #45.

During an interview with Staff #109, the staff member indicated to the inspector that the incident of suspected staff to resident abuse that was reported "occurred two or three years ago" and could not recall which resident was involved in the incident. Staff #109 confirmed receiving annual mandatory training on the home's zero tolerance of abuse and neglect policy in 2014 and was aware of the requirement to immediately report suspected staff to resident abuse to the supervisor.

A review of the home's internal investigation documentation contained a signed

statement from Staff #109 stating "the suspected physical abuse of [Resident #45] by [Staff #107] occurred approximately two months prior to reporting.

During an interview with Unit Manager #2, indicated that Staff #109 reported to the Unit Manager that on a specified date(approximately two months prior), witnessed staff to resident physical abuse by Staff #107 towards Resident #45.

The scope and severity was that one staff member (#107) did not follow the home's Zero Tolerance of Abuse and Neglect (Resident) policy #14-18 by engaging is physical abuse towards Resident #45 and a second staff member (#109) failed to comply with the same policy as the staff member witnessed the staff to resident abuse incident towards Resident #45 and failed to immediately report the incident to a supervisor or manager. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided to Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During an interview of the President of the Residents Council, stated "could not recall if the Residents Council received written responses within 10 days when there is a concern or recommendation brought forward by the Residents Council".

A review of the Residents Council meeting minutes for four separate months indicated that the Residents Council raised concerns related to resident care and the operation of the home but the Residents Council did not receive a written response to these concerns for approximately 17-20 days later.

An interview of the Coordinator of Resident and Family Services (CRFS) indicated they are the appointed assistant to the Residents Council. The CRFS indicated the Residents Council did not receive a written response within 10 days when concerns or recommendations were brought forward on the four specified months.

The Administrator also confirmed that a written response was not given within 10 days to the Residents Council when concerns or recommendations were brought forward by Residents' Council on the four specified months. [s. 57. (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 written response is provided to the Residents Council within 10 days of receiving Resident Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the

Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Related to Log # 001923-15:

The Licensee has failed to ensure that staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Review of the health record for Resident #8 indicated the resident has a history of fractures and had been identified as a high risk for falls. Review of the progress notes during a five month period indicated Resident #8 had fallen four times. The third fall resulted in an injury requiring transfer to hospital and change in resident condition. The last fall identified that on a specified date and time, the resident did not have a restraining device in place (as ordered by the physician for safety and to prevent falls), the resident sustained a fall resulting in injury and transfer to hospital and change in condition. The staff indicated they were not aware Resident #8 was to have the restraining device in place.

Interview with Unit Manager #1 indicated that on a specified date and time, Resident #8 (at the time of the fall) did not have the restraining device in place.(601). [s. 110. (2)]

2. The licensee has failed to ensure that staff release the resident from the physical device and reposition at least once every two hours.

Review of the health record for Resident #26 indicated a physicians order for the use of a restraining device while up in a mobility aide for safety and to prevent falls.

Review of the care plan for Resident #26 related to restraint use directs staff to check the resident every hour when in restraint and reposition every 2 hours.

On May 11, 2015 at approximately 11:00 hrs Resident#26 was observed sitting in a mobility aide with a restraining device in place.

Interview with Staff #206 indicated Resident #26 is monitored every hour but the repositioning time frame is not completed every two hours as two staff members are required at times to reposition the resident. [s. 110. (2) 4.]

3. The licensee has failed to ensure that that there is documentation which includes every release of a physical device and all repositioning.

Inspector #549 observed Resident #32 with two restraints in place during Stage 1 of the Resident Quality Inspection.

A review of Resident #32's health care record indicates Resident #32 has a physicians order for two restraints in place at all times when up in mobility aide.

The home's "Restraining of Residents - Minimizing" (policy No. 8-210) last reviewed December 2013 indicated on page 5: E) Responsibility of HCA's 1. Check the restraint hourly, 2. Release and reposition the resident every 2 hours, 3. Follow care plan interventions, 4. Document hourly on electronic Point of Care (POC) restraint monitoring record.

Inspector #549 reviewed the POC restraint monitoring record for Resident #32 for a two month period:
-On a specified date, indicated the resident's restraints were applied at 17:49 and removed at 22:22. There was no documentation for Resident #32 indicating that during those 4.5 hours the two restraints were released and the resident was repositioned.
-On a second specified date, indicated the resident's two restraints were applied at 10:35hrs and removed at 13:27 hrs. There was no documentation for Resident #32 indicating that during those 3 hours the two restraints were released and the resident was repositioned.
-On a third specified date, indicated the resident's two restraints were applied at 09:31hrs and removed at 20:45 hrs. There was no documentation for Resident #32 indicating that during those 11 hours the two restraints were released and the resident was repositioned.
-On a fourth specified date, indicated the resident's two restraints were applied at 09:21 hrs and removed at 13:29 hrs. There was no documentation for Resident #32 indicating that during those 4 hours the two restraints were released and the resident was repositioned.
-On a fifth specified date, indicated the resident's two restraints were applied at 15:15 hrs and removed at 20:58 hrs. There was no documentation for Resident #32 indicating that during those 5.5 hours the two restraints were released and that the resident was repositioned.
-On a sixth specified date, indicated the resident's two restraints were applied at 10:54 hrs and removed at 20:59 hrs. There was no documentation for Resident #32 indicating that during those 9 hours the two restraints were released and that the resident was repositioned.
-On a seventh specified date, indicated the resident's two restraints were applied at 07:36 hrs and removed at 13:32 hrs. There was no documentation for Resident #32 indicating that during those 6 hours the two restraints were released and that the resident

was repositioned.
-On an eighth specified date, indicated the resident's two restraints were applied at 17:46 hrs and removed at 20:50 hrs. There was no documentation for Resident #32 indicating that during those 3 hours the two restraints were released and that the resident was repositioned.

During an interview with Staff #203 it was indicated that PSW's are responsible for documenting in the POC the release of the restraint and the repositioning every 2 hours.

During an interview with Staff #204 it was indicated that the two restraints for Resident #32 are released and the resident is being repositioned every two hours. Staff #204 also indicated that the software program (POC) used to document the release of the restraint and all repositioning does not reflect the actual release and all repositioning.

During an interview with Staff #207 indicated "was aware of the documentation issue and would be speaking to management to rectify the software issue".

During an interview of Unit Manager #1 confirmed that every release of the restraint and all the repositioning of the resident "is not always being documented". [s. 110. (7) 7.]

4. Observation of Resident #16 indicated the resident was up in a mobility aide with trunk restraint in place.

Interview of Staff #104 indicated Resident#16 is placed in mobility aide every morning before breakfast (at approximately 08:00 hrs) and then returned to bed at approximately 18:30 hrs. Staff #104 indicated the trunk restraint is applied when the resident is placed into the mobility aide and removed when returned to bed.

Review of POC for Resident #16 (for a two month period) indicated the trunk restraint is applied at approximately 10:30 hrs and removed at approximately 20:30 hrs. The documentation also did not indicate every two hour release/repositioning/reapplication. [s. 110. (7) 7.]

5. Interview with Staff #206 indicated Resident #26 is placed into the mobility aide by 8 am every day and the trunk restraint is applied at that time.

Review of POC documentation for a two month period indicated the trunk restraint was being applied at approximately 10am and removed at various times in the evening.

Monitoring and repositioning/releasing of the seat belt was not being consistently documented as outlined in the home's policy (552). [s. 110. (7) 7.]

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 staff apply physically restraining devices in accordance with any instructions specified by the physician or registered nurse in the extended class, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents have his/her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

The home's pharmacy provider supplies the resident's medications in single unit dosage packets for each individual resident. The residents' name, room number, name of medication, dosage, date and time the medication is to be administered is printed on each individual medication packet.

On May 12, 2015 the 08:00 medication administration pass was observed by Inspector #549 on a specified unit. During the medication administration pass it was observed by Inspector #549 that the used medication single unit dosage packets were put into the garbage bin attached to the medication cart.
Staff #106 indicated to Inspector #549 that the garbage bag from the medication cart is tied up then housekeeping staff come to the unit and take it to the garbage compactor. Staff #106 indicated this is the home's practice on each of the resident units for all medication administration passes.

During an interview with Inspector #549 Unit Manager #1 confirmed that the home's present practice is to put the resident's used medication single unit dosage packets in the garbage compactor. Unit Manager #1 also confirmed that the garbage compactor does not remove or destroy the resident's personal health information which is printed on the medication single unit dosage packets. During the same interview Unit Manager #1 confirmed the garbage bag which contains the resident's personal health information is picked up by the city's garbage workers and disposed of in the city's landfill. Unit Manager #1 indicated to Inspector #549 that recent discussions have taken place with the nursing staff to change the practice and start putting water in the garbage bag with the used medication packets to remove or destroy any personal health information before sending it to the garbage compactor. However, this practice has not been implemented at the time of this inspection. [s. 3. (1) 11. iv.]

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure the residents plan of care related to toileting/continence set out clear directions to staff and others who provide direct care to the resident.

MDS data during a specified date indicated Resident #41 was identified as "high risk for incontinence with worsening bladder incontinence".

A review of Resident #41's care plan related to bladder continence indicates the resident is occasionally incontinent of bladder, and to check for wetness at morning care, before and after meals,at bedtime care, evening rounds, and both night rounds. The care plan also indicated requires limited assistance to direct resident to the toilet.

A review of the Kardex(posted in Resident #41's room) indicates the resident is continent of urine and is routinely toileted by staff, as resident is not able to recognize or find the toilet.

Interview with Staff #206 indicated Resident #41 had bladder incontinence despite

regular toileting before and after meals by staff. Interview with Staff #205 and #207 indicated that Resident #41 was no longer able to locate the toilet without assistance from staff, and has occasional bowel and bladder continence.

Therefore, it was unclear as to whether Resident #41 was continent or incontinent of bladder, and it was unclear which level of assistance the resident required related to toileting. [s.6.(1)(c)]

2. The licensee has failed to ensure that the plan of care was provided to the resident as specified in the plan related to falls risk.

Related to Log # 001923-15:

Review of the health record for Resident #8 indicated the resident had a history of dementia, fractures, and had been identified as a high risk for falls.

Review of Resident #8 current care plan indicated the resident was a "high Risk for falls" related to high Morse Fall Score, poor positioning, and cognitive impairment. Interventions included:
-trunk restraint in place when in mobility aide for safety and to prevent falls.
-Falling Star Program participant: Staff to recognize resident's high risk for falls. Icon placed on doorway to alert staff, to guide resident's daily routine.
-Leave nightlight on, Bed in the lowest position whenever resident is in it, and fall out mat on both sides of bed.
-Do not take to room after dinner meal, NOT to be left unattended in w/c in the evening. To remain in COMMON AREA until staff take the resident to room for HS routine as the resident will try to get up on own.
-Resident to wear proper and non-slip footwear, teach resident to transfer and change positions slowly.
-Reinforce need to call for assistance, ensure call bell is accessible at all times, and call bell clipped to gown when in bed.
-Have commonly used articles within easy reach.

Review of the progress notes indicated Resident #8 had fallen four times in five month period. Two falls resulted in injury requiring transfer to hospital and change in condition. The last fall that resulted in an injury requiring transfer to hospital and change in condition indicated the resident did not have the trunk restraint in place at the time of the fall as ordered by the physician.

Interview with the Unit Manager #1 confirmed that when Resident #8 sustained the last fall, the restraint was not in place as specified in the plan of care.

An order was issued for LTCHA, 2007 s.6.(7) under report #2015_360111_0003 with a compliance date of April 30, 2015 and now found to be in compliance. [s. 6. (7)]

3. The license failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care

Related to log #001775:

A Critical Incident report was received on a specified date indicating that earlier the same date, the staff were alerted by the resident's spouse that Resident #47 had fallen. The resident was transferred to the hospital due to an injury and subsequently died.

Review of health care record for Resident#47 indicated:
- the resident's condition had been deteriorating for approximately one month period (with increased confusion and poor decision making) and during that period, the resident sustained 7 unwitnessed falls which predominantly occurred in the resident's bedroom.
-On a specified date (during the same time period) the resident was reassessed by the Physiotherapist (PT) who recommended the resident "should have protective hat to prevent any head injuries".

The plan of care for Resident #47 identified the resident as high risk for falls and included the following strategies:
-Teach resident to transfer and change positions slowly.
-Reinforce need to call for assistance, ensure call bell is accessible at all times. Remind to not try to unplug items without assistance (prevent tangling of cords).
There was no indication of recommendation for protective hat included in the plan of care.

Interview with PT indicated during the one month period, the resident had become very confused and was over estimating abilities. The resident had also began using a manual mobility aide. Resident #47 had several falls between during the same time period and had made the recommendation for protective hat to be worn and expected that this would have been documented in the care plan and implemented.

During an interview with Staff #111 the recommendation made by the PT regarding protective hat was discussed. Staff #111 acknowledged that this recommendation should have been implemented and included in the resident's care plan. There is no evidence that this recommendation was implemented by staff.

Therefore, there was no indication that when the plan of care was being reviewed and revised, different approaches were considered in the revision. The strategies that were identified were not effective in minimizing the falls (as the resident was confused and had poor decision making skills). The use of the protective hat had been recommended by the PT but was not considered in the revision of the plan of care. [s. 6. (11) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff.

Related to log #001824 & #001842:

A critical incident report was submitted to the Director on a specified date for an allegation of staff to resident neglect that occurred over a two day period approximately 10 days before it was reported. The CIR indicated 14 residents were alleged to be neglected by Staff #107. The staff member alleged to have neglected the resident's no longer works in the home.

A complaint was also received by the SDM of Resident #43 (who was one of the residents involved in the staff to resident neglect) expressing concern over the staff to resident neglect.

Review of the home's investigation into the allegation of staff to resident neglect indicated that on a specified date (10 days later) a staff reported an allegation of staff to resident neglect. During the home's investigation, they confirmed that 14 residents did not receive care according to their plan of care. The home's investigation also confirmed that 6 other staff were aware of the staff to resident neglect by Staff #107 that occurred on two specified dates involving Staff #107 but did not immediately report the suspicion to their supervisor/manager.

Interview of the Executive Director (ED) and two Unit Managers (who completed the home's investigation) indicated no other actions were taken as a result of the home's investigation, despite 7 staff failing to immediately report neglect. The ED indicated that no further actions were taken "because the employee involved" no longer worked in the home.[s.23(1)(b)]

2. Related to Log # O-001825-15

On a specified date, Staff #109 reported to Unit Manager #2 a suspected staff to resident physical abuse incident towards Resident #45 by Staff #107.

A review of the home’s Internal Investigation Form indicated that Staff #109 was aware of the suspected physical abuse of Resident #45 by Staff #107 that occurred two months prior but did not report the suspected abuse to Unit Manager #2 two months after.

During an interview with Staff #109 it was indicated to Inspector #549 that the incident "occurred two or three years ago" involving "a different resident". Staff #109 could not recall the resident, however stated the resident "had passed away". Staff #109 gave no indication as to why the staff member did not immediately report the suspected physical abuse.

The home's Internal Investigation documentation contained Staff #109's signed statement indicating the suspected incident of abuse of Resident #45 by Staff #107 occurred approximately two months prior. The home's Internal Investigation Form also indicated the investigation was concluded when Staff #107 resigned.

During a telephone interview Unit Manager #2 confirmed to Inspector #549 the suspected physical abuse of Resident #45 by Staff #107 occurred two months prior and was reported to the UM #2 by Staff #109 on two months later.

A review of the Unit Managers notes (dated at time of incident) indicated Unit Manager #2 was aware that an incident occurred with Resident #45 on that date because the Unit Manager #2 documented that "[Staff #107] was heard yelling in the dining room and stated that Resident #45 had demonstrated physically aggressive behaviour towards Staff #107. Unit Manger #2 indicated there was the "suspicion" by Staff #109 that Staff #107 was physically abusive towards Resident #45 at that time but no further action was taken. Unit Manager #2 confirmed that no other action was taken in relation to Staff #109 not reporting the suspected physical abuse immediately. [s. 23. (1) (b)]

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. (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 has failed to ensure that the results of the satisfaction survey was made available to the Family Council.

The Family Council president explained during an interview that the results from the last satisfaction survey has not been received from the home.

Interview with Staff #115 confirmed that the results of the survey were not provided to the Family Council. [s. 85. (4) (a)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure the Director was informed immediately, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

Log#O-001923-15:

A Critical Incident Report was submitted to the Director on a specified date for an unexpected or sudden death of a resident that occurred the day before.

During an interview of Unit Manager #2 indicated the Director was not notified until the CIR was submitted (approximately one day later). [s. 107. (1) 2.]

Issued on this 28th day of May, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), KARYN WOOD (601), MARIA FRANCIS-ALLEN (552), RENA BOWEN (549)
Inspection No. / No de l'inspection :	2015_360111_0011
Log No. / Registre no:	O-001963-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 22, 2015
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Gillespie

To MARYCREST HOME FOR THE AGED, 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. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall review any and all residents with current and/or previously existing seat belt covers in place, to determine which residents were charged for these seat belt covers, the amount charged, and reimburse the resident/SDM for those charges.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Related to log# 001875:

Review of the health record of Resident #53 & #54 indicated the residents were noted to have restraint covers in use.

Inspector #601 observed Resident #54 on a specified unit sitting in a mobility device with a restraint and restraint cover in place.

Inspector #601 interviewed Staff #124 who indicated that families are notified by the registered staff when a resident requires a restraint cover as "an added

restraint". The staff member indicated the registered staff will notify Motion Specialties after obtaining consent from families to purchase the restraint covers. The staff member was not sure of the cost involved.

Inspector #549 observed Resident #57 and #58 on a specified unit in the dining room with a restraint in place and restraint cover in place.

Inspector #549 interviewed Staff #122 who stated Resident #53 also had a seat belt cover "but it was lost some time ago". Staff #122 stated that Resident #53 no longer uses the restraint cover. Staff #122 stated "when a resident is assessed and requires a restraint cover, the nursing staff will contact the resident's POA and obtain consent to use the restraint cover. Motion Specialties is then contacted by the home to provide the restraint cover. A charge for the restraint cover is then submitted to the resident's POA".

Interview of Staff #123 by Inspector #111 on a specified unit indicated Resident #55 & #56 used restraint covers and they were used to prevent the resident's from removing the restraints. The Staff indicated the families are contacted for permission to order the restraint cover as there is a $25.00 charge by "Motion Specialties", who then send the family the bill. The staff member indicated Resident #55 no longer uses the cover as it had been lost. The staff member indicated that Resident #56 still uses the restraint cover.

Observation by Inspector #111 of Resident #55 indicated no restraint cover was in place. Observation of Resident #56 indicated no restraint cover was in use despite the restraint in use. The restraint cover was located int he resident's bathroom.

Interview of the Administrator indicated no knowledge of use of restraint covers in the home and had no knowledge of families being charged for the restraint covers.

The scope of the issue was that the use of restraint covers was widespread as they were being used throughout the home and the practice of charging for non-allowable charges (safety devices) has been ongoing. [s. 245. 3.] (111)

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 30, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan that will address the following:
-ensure that all alleged, suspected, or witnessed incidents of staff to resident abuse and/or neglect is immediately reported, investigated, and appropriate actions are taken pending the outcome of the investigation. This part of the plan must be implemented immediately.
-retrain all staff on what constitutes staff to resident abuse and/or neglect and reporting requirements of same.
-retraining of all unit managers, and management staff regarding responsibilities for investigating all alleged, suspected or witnessed incidents of staff to resident abuse and/or neglect, and appropriate actions to be taken (pending outcome of investigations), as per the home's prevention of abuse and neglect policy.
-the implementation of a monitoring plan to ensure on-going adherence to the licensee's policy re abuse/neglect.
-the plan is to include who will be responsible for each action, and the date the action is to be completed by.

This corrective action plan is to be submitted to Lynda Brown, LTCH Inspector (Nursing) via email to: Lynda.Borwn2@ontario.ca by June 1, 2015.

Grounds / Motifs :

1. Related to Log #001825:

A Critical Incident Report was submitted to the Director on a specified date indicating a suspected staff to resident physical abuse towards Resident #45.

During an interview with Staff #109, the staff member indicated to the inspector that the incident of suspected staff to resident abuse that was reported "occurred two or three years ago" and could not recall which resident was involved in the incident. Staff #109 confirmed receiving annual mandatory training on the home's zero tolerance of abuse and neglect policy in 2014 and was aware of the requirement to immediately report suspected staff to resident abuse to the supervisor.

A review of the home's internal investigation documentation contained a signed statement from Staff #109 stating "the suspected physical abuse of [Resident #45] by [Staff #107] occurred approximately two months prior to reporting.

During an interview with Unit Manager #2, indicated that Staff #109 reported to the Unit Manager that on a specified date(approximately two months prior), witnessed staff to resident physical abuse by Staff #107 towards Resident #45.

The scope and severity was that one staff member (#107) did not follow the home's Zero Tolerance of Abuse and Neglect (Resident) policy #14-18 by engaging is physical abuse towards Resident #45 and a second staff member (#109) failed to comply with the same policy as the staff member witnessed the staff to resident abuse incident towards Resident #45 and failed to immediately report the incident to a supervisor or manager. [s. 20. (1)] (549)

2. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's "Abuse and Neglect (Resident)-Zero Tolerance" (policy #14-18) reviewed March 2015, states the following on Page 8, Section B, Number 3: All those who witness or have knowledge of reasonable grounds for suspicion of abuse are required to report it to a supervisor or manager immediately in accordance with Section 24(1) of the LTCHA. The policy also indicated on page 10 of 15, under #2."Responsibility of Employees who witness or suspect alleged abuse or neglect to" report any witnessed, suspected, or alleged abuse to a supervisor or manager immediately.ON page 14 of 18 indicated "anyone failing to report witnesses or suspected abuse is in contravention of the requirements of MOHLTC and St. Josephs' of Fleming requirements.

Related to log #001824 & #001842:

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of staff to resident neglect that occurred over a two period. The CIR indicated the allegation was related to several resident being neglected by Staff #107, the allegation was reported the same day as the submission of the CIR, but the incidents occurred 10 days before it was reported. A complaint was also received regarding this incident.

Review of the home's investigation into the allegation of staff to resident neglect indicated the incidents of neglect of care occurred over a two day period by Staff #107. Six staff (which included Staff #118 & #119) had knowledge of the staff to resident neglect by Staff #107 and did not immediately report the neglect. Staff #107 no longer works in the home.

Interview of the 2 Unit Managers indicated "very concerned that staff were aware and did not immediately report".

Interview of Staff #118 & #119 identified receiving annual prevention of abuse and neglect training which included their reporting requirements, and were aware of what constituted neglect.

The home did not comply with the home's "Abuse and Neglect (Resident)-Zero Tolerance" as 6 staff had reasonable grounds to suspect staff to resident neglect and did not immediately report. [s. 20. (1)]

The home was issued non-compliance previously related to LTCHA, s. 20 during a follow up inspection # 2013_184124_0010 and again during inspection # 2013_184124_0011 on July 7, 2013. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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