Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2016	2016_461552_0023	002446-16	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's at Fleming
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

MARIA FRANCIS-ALLEN (552), BAIYE OROCK (624), CATHI KERR (641), KARYN WOOD (601), LYNDA BROWN (111), SAMI JAROUR (570)

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): August 9, 10, 11, 12, 15, 16, 17, 18 & 19, 2016

Complaint logs # 033114-15 related to infection control and # 014895-16 related to resident care
Critical Incident logs # 034994-15, # 035574-15, # 019519-16, # 019002-16, # 013952-16 related to falls; # 001592-16 related to medication; # 009254-16, # 012140-16, # 016598-16 and # 016155-16 related to allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Care (DOC), Manager of Quality and Education, Home Area Managers, Nurse Practitioner, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Food Services Manager (FSM), Physiotherapist Assistants (PTA), Personal Support Workers (PSW), Social Services Worker (SSW) , Environmental Service Manager (ESM), Maintenance Worker, Resident Council President, Family Circle President, family and residents.

Also conducted tour, observed dining service, administration of medication, interaction of staff to resident during provision of care, reviewed the minutes for Resident Council and Family Circle, the home's policies related to Falls, Abuse, Infection Control, Weights and Heights - Monitoring of resident's Weight

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Re: Log # 001592-16:

A Critical Incident Report (CIR) was submitted by the home on an identified date for a medication incident that occurred the previous day. RPN #105 was observed in the home under the premise of picking up an item from a co-worker. The staff member then stated to RPN #148 he/she would visit resident #044 before going home. RN #122 confirmed with RPN #148 that prior to RPN #105's visit with resident #044, the controlled substance was in place. RPN #148 again checked the controlled substance for resident

#044 once RPN # 105 had left and informed the RN it was no longer in place. Resident #044 described to RPN #148 the person who had removed the controlled substance and the description fitted RPN #105.

During the home's investigation, RPN #105 admitted he/she had stolen the controlled substance and that this was not the first time he/she had done this.

Interview with RN #120 indicated after the incident , the RN reviewed all the missing controlled substances throughout the home and discovered that over a 6 month period, there were 31 incidents of missing controlled substances. The RN confirmed that any missing narcotic required a medication incident report to be completed and that an email had been sent to all home areas reminding registered nurses to complete this form and to check all residents with controlled substances at the start of their shifts. The RN confirmed that only 13/31 missing controlled substances incidents had a medication incident report completed which would indicate the resident had been assessed, incident reported to SDM, Director of Care (DOC), Medical Director and pharmacy.
Review of the 13 medication incident reports indicated the residents had been assessed and there was no harm as a result. Only 11/13 indicated the SDM, DOC and physician was notified. Only 2/13 reports indicated the pharmacy was notified.

Review of the Medication Incident audits completed by pharmacy indicated awareness of three incidents of missing controlled substances over a three month period but no actions were identified to prevent a recurrence. [s. 135. (1)]

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

Re: Log # 001592-16:

A CIR was submitted by the home on an identified date for a medication incident that occurred the previous day. RPN #105 was observed in the home and visiting resident #044. RN #122 confirmed with RPN #148 the controlled substance was no longer in place after RPN #105 ended the visit with resident #044. Resident #044 described RPN #105 as having removed the controlled substance.

Review of the home's investigation, medication incident reports, interview of staff, and

review of the pharmacy/home medication incident audits indicated:
-over a 6 month period there were 31 incidents of missing controlled substances involving five different residents (resident # 044, #060, #061, #062 & #063)
-only 13/31 missing controlled substance incidents had a medication incident report completed (despite an email reminder to nursing staff to complete the report and check for any missing controlled substances).
- only 11/13 medication incident reports had the SDM, DOC and physician notified.
- only 3/31 missing controlled substances had documented evidence to indicate the pharmacy was notified.
-only 1/31 missing controlled substance incidents was reported to the Director.
-after the Director was notified on an identified date of the missing controlled substance, additional action was not taken until five weeks later (changing of exterior door codes) despite the home having awareness that RPN #105 was involved in the missing narcotics.
-review of the Medication Incident audits (completed from pharmacy) indicated awareness of three incidents of missing controlled substances (over a three month period) but no actions were identified to prevent a recurrence.
-review of the medication incident audits completed by the home indicated awareness of six incidents of missing controlled substances and no actions were identified to prevent a recurrence. [s. 135. (2)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

Re:critical incident log # 009254-16 for resident #048

A CIR was submitted by the home on an identified date for an allegation of staff to resident neglect. The CIR indicated that five days earlier, resident #048 reported to the receptionist and the Chief Executive Officer (CEO) he/she had missed three baths during an identified month. An after hour call was received by the Director on the same date the resident made the complaint.

Review of resident #048 care plan (in place at that time) related to bathing indicated the resident required supervision with bathing, and prefers a daily shower. Interventions included: provide physical help in part of bathing activity with one staff, no longer safe unassisted in shower, agrees to a tub bath, hair washed and finger nails cut.
-review of the "bath List" for an identified unit indicated resident #048 was scheduled to have two baths per week on specific days and shifts.
-review of the PSW's "Documentation Survey Report" for an identified month under bathing indicated: the resident received two baths in that specific month.
-review of the progress notes indicated on an identified date the PSW reported the resident "missed his/her bath and gonef to bed before HCA got there. Will have it the next day". The resident was not scheduled to have the bath on an identified date and there was no documented evidence the resident had the bath the following day.

Inspector #111 was unable to interview RN #121 (who was responsible for conducting the investigation within the home) no longer works in the home.

The licensee failed to ensure that the resident received two baths as set out in the plan of care. (111) [s. 6. (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 ensure the care related to bathing set out in the plan of care is provided to all residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect any of the following has occurred, immediately report the suspicion and the information upon which it was based to the Director, 1.Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Re: Log # 012140-16 for resident #046 & #047:

A CIR was submitted by the home on an identified date for an allegation of staff to resident physical abuse. The CIR indicated that three days earlier, RPN #103 was providing treatment for an injury to resident #046 & #047. Both residents reported the injury were sustained during care by PSW #106. Resident #046 reported PSW #106 "is always so rough" and resident #047 reported "they forced me into my clothes".

An after hours call was received from the home, the day after the allegation was made and not within legislated timelines. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or risk of harm is immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure the most recent minutes of the Family Council meetings, if any, with consent of the Council were posted and communicated. s. 79. (3) The required information for the purposes of subsections (1) and (2) is, (o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3).

A tour of the home was conducted and the most recent minutes from the June 24, 2016 Family Council meeting was not posted.

During an interview on August 17, 2016 the President of the Family Council identified that Family Council was referred to as Family Circle. The President of Family Circle indicated that following the approval of the Family Circle meeting minutes a copy of the minutes is forwarded to the liaison of the home.

During an interview on August 17, 2016, the Social Service Worker (SSW) indicated that he had received the meeting minutes from the Family Circle on July 22, 2016 at 1346 hours. During an interview on August 18, 2016 the SSW indicated the Family Circle meeting minutes had not been printed or posted in the home.

During an interview on August 18, 2016 , the DOC indicated the Family Circle had not requested the meeting minutes to be posted in the home. [s. 79. (3) (o)]

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 the most recent minutes of the Family Council meetings (called Family Circle within the home) are posted, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed no later than one business day after the occurrence of the incident of:
3. A missing or unaccounted for controlled substance.

Re: Log # 001592-16:

A CIR was submitted by the home on an identified date for a medication incident that occurred the previous day. RN #122 observed RPN #105 in the home speaking with a co-worker (RPN#148). The RN approached RPN #148 to ask why RPN #105 was in the home and was informed RPN #105 was visiting resident #044. RN #122 and RPN #148 went to resident #044 room to check the controlled substance was in place and confirmed at a specific time that it was still in place. Once RPN #105 had left the home, RN #122 asked RPN #148 to check the controlled substance for resident #044 again as the RN "was uneasy about the presence of "RPN #105 in the home area". RPN #148 informed the RN the controlled substance was no longer in place. Resident #044 described RPN #105 as having removed the controlled substance.

The RN indicated upon reviewing missing controlled substances throughout the home, it was discovered over a six month period, there were 31 incidents of missing controlled substances. The RN indicated the only incident that was reported was the incident that occurred on an identified date because RPN #105 admitted to taking the controlled substance. The RN was unaware that all missing or unaccounted for controlled substances were to be reported to the Director within one business day. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is informed no later than one business day after the occurrence of all missing and unaccounted for controlled substances and that the registered nursing staff are retrained on medication incident reporting, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that staff participates in the implementation of the infection prevention and control program.

During the tour of the home on August 9, 2016, the following rooms were observed to have Personal Protective Equipment (PPE) supplies hanging on the door with no signage to disclose the type of precautions the resident was on:
- Inspector #111, # 641 and # 624 all observed PPEs hanging on the doors of three different residents rooms.
- Inspector #111 interviewed PSW #100 regarding the PPE's on the door of an identified room and the staff member indicated he/she was new and unsure what type of isolation the resident was on.
In an interview with PSW #101, RPN #148 and NP #152 all three identified the reason and type of isolation the residents were supposed to be on. Both PSW #101 and RPN #148 confirmed there was no signage posted on the door and the expectation is that there should be a contact precaution sign on residents doors.
The DOC also confirmed that whenever a resident is on isolation, the Home's expectation is there are both PPE supplies hanging on the resident's door and a signage indicating the type of precautions. [s. 229. (4)]

2. The licensee has failed to ensure that symptoms of infection in residents are monitored on every shift in accordance with evidence-based practices and if there are none, in accordance with prevailing practices

Review of the clinical health records indicated that on an identified date, resident #006 was assessed and diagnosed with respiratory infection by the Nurse Practitioner (NP) #152. Between an eleven day period, when the antibiotic treatment was completed and the resident was noted to be asymptomatic, there were only 3 progress notes documenting the resident's condition. The resident's temperature was recorded 9 of the 10 days during that same period.
RN #124 and Home Area Manager #104 both stated the expectation of the home was that the resident would be monitored every shift for signs and symptoms of the respiratory infection and this would be documented in their chart. This would continue until the resident no longer showed any signs or symptoms of the infection.
NP #152, who is also the Infection Control lead for the home, stated the staff should take vital signs daily, monitor the resident and document their symptoms daily in the home's electronic software.
As per the home's Policy No. 5-03, Acute Respiratory Infection, under section #1. (d), staff are expected to perform ongoing daily assessments of residents with acute respiratory infections.

The licensee has failed to ensure that symptoms of infection in resident #006 were monitored on every shift in accordance with evidence-based practice. [s. 229. (5) (a)]

3. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

On August 9 & 10, 2016 , resident #058 had PPE's hanging on the door and there was no sign to indicate why the PPE's were present.

During an interview PSW #100 was unable to indicate why the resident was on isolation or what type of isolation precaution was in place.

Interview with the RPN indicated PSW #100 was new and may not have been aware of why the resident was on isolation but it was for respiratory isolation as the resident had an infection. The RPN indicated the resident was treated with medication and has since been removed from isolation.

Review of the Monthly Infection Control Form (each unit) indicated resident #058 started on an identified date with symptoms of a temperature, cough and malaise. The resident had upper respiratory infection and was placed on medication and isolation.

Review of the progress notes indicated:
- on an identified date the resident complained of symptoms of an infection was given medication.
- the following day the resident continued to show signs and symptoms of an infection.
- there was no documentation on the following day.
- the following day the resident continued to complain of symptoms of an infection and requested to remain in bed.
- the following day the resident's son reported the resident was not feeling well and exhibiting specific symptoms. The resident was assessed and was given medication.
- the following day the resident exhibited other symptoms and was placed on "precautionary isolation". The physician was contacted and ordered medications and a diagnostic test. The resident was diagnosed with an respiratory infection.
- the resident continued to improve and on an identified date the resident was removed from isolation.

The resident was demonstrating symptoms of infection on an identified date and staff did not record symptoms on every shift. Action was not taken until six days later when the resident was placed on isolation and the physician was contacted. [s. 229. (5) (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents have their personal items, including personal aides such as dentures, glasses and hearing aides labelled within 48 hours of admission and in the case of acquiring new items.

During the initial tour of the home the following was noted:
Inspector #111 observed in an identified unit's unit spa rooms :
- : 4 brushes, 2 combs, and 2 nail clippers that were used and unlabelled in a drawer labelled "hair items".
-: 6 combs and 2 brushes that were used and unlabelled placed in a drawer labelled "hair items".

Inspector #624 observed in an identified unit spa room
- Silicone skin cream, two bottles of shampoo and one bottle of body lotion.

Inspector #641 observed in identified units spa rooms :
-: Tub room: body shop lotion, axe deodorant, Tresemme shampoo, toothpaste, 3 deodorant used and unlabelled. 1 brush and 5 combs that were used and unlabelled in a drawer labelled "hair items".
-: In tub room:3 brushes that were used and unlabelled placed in a drawer labelled "hair items" and hand lotion, old spice deodorant , 3 shaving cream, 2 body lotion, and 1 bottle of perfume that were unlabelled and used. In shower room:. 2 shaving creams.

During an interview, PSW #100 explained to inspector #111 he/she was new and was not aware of which residents the combs/hairbrushes belonged to and agreed they should be have been labelled.

During an interview PSW #102 explained to inspector #624 that the expectation of the Home is that such personal care items should always be labeled with the resident's name.
In an interview with Unit Managers #104, she confirmed the expectation is that resident personal care items should be labelled at all times, especially when in common care areas. The DOC also confirmed the expectation to have resident personal care items labelled at all times. [s. 37. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the development of nutrition care and hydration program that includes policies and procedures related to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff, was implemented.

Under O.Reg. 79/10, s. 68(1)(e) a weight monitoring system to measure and record with respect to each resident, (ii) a body mass index and height upon admission and annually thereafter.

Review of the home's policy "Weights and Heights-Monitoring of Resident" (8-246) indicated:all residents are weighed and height obtained within 48 hours of admission. Thereafter, heights will be measured annually.

Interview with PSW #123 indicated the heights of residents are completed by the PSW's

and completed on admission and when directed by the Registered Nursing staff.

Interview with RN #124 indicated the resident heights are completed on admission and annually before the care conference by the PSW's. The RN indicated a note is left in the communication book at nursing station to notify the PSW's to complete.

During stage one of the Resident Quality Inspection (RQI), census record reviews and staff interviews identified 10/40 residents had not had their heights completed annually:
-resident #001 (last completed in 2014); resident #002 (last completed in June 2015) as noted by Inspector #641.
-resident #010, #012 & #013 (last completed in 2014) as noted by Inspector #111.
-resident #020 & #21 (last completed in 2014); resident #022 (last completed in 2012) as noted by Inspector #570
-resident #036 (last completed in 2013) and resident #037 (last completed in 2008) as noted by Inspector # 552. [s. 68. (2) (a)]

2. The licensee has failed to ensure that the development of nutrition care and hydration program that includes policies and procedures related to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff, was implemented.

Review of the home's policy "Weights and Heights - Monitoring of Resident (8-246) indicated the following:
Page 1 of the policy, under Policy Statement states that resident weight will be obtained and documented in Point of Care (POC) within 48 hours of admission and at least monthly. All weight loss or gain in excess of 2 kg will requires a re-weight, and a referral will be made to the RD for significant weight change.

Page 2 of the policy, under responsibility of Health Care Aide:
-. Compare weight obtained to previous month weight to determine if a re-weigh is required.
- Reweighs are required for any resident with a weight variance (from the previous month) of 2 kg.
- Report any variances of 2 kg or greater to Registered Staff immediately.

Related to resident #019:

Review of clinical records for resident #019 indicated the resident is diagnosed with

cognitive and identified at moderate nutritional risk. The resident continues to receive a modified diet with regular texture. Resident #019 was noted to have a significant weight change of 3.6 kg over a 2 month period.

Review of progress notes for resident #019 indicated no re-weight was completed when the resident had a weight variance of 3.6 kg on an identified date. The home's Registered Dietitian (RD) assessed resident #019's weight gain and indicated the resident's weight has increased significantly in one month and the resident's current weight remains within the usual weight range of the resident.

During an interview on August 15, 2016, the RD confirmed to inspector #570 that resident #019 had a weight gain of 3.6 kg on an identified date of 3.6 kg and the resident should have been re-weighed.

Related to resident #022:

Review of clinical records for resident #022 indicated the resident is diagnosed with dementia and identified at high nutritional risk. The resident receives regular diet with regular texture and continues to be resistive with staff assisting at meals and the resident's intake fluctuates from refusal to full.

Over a 4 week period resident #022's weight is noted to differ by 2.5 kg and there is no documented reweigh completed. Between a 4 week period resident #022's weight is noted to differ by 2.4 kg and there is no documented re-weigh completed.

During an interview on August 15, 2016, the RD conformed to inspector #570 that resident #022's had a drop in weight of 2.4 kg in an identified month and weight gain of 2.5 kg two months earlier. The RD indicated the resident should have been re-weighed as the weight variance exceeds 2 kg as per policy.

Related to resident #006:

Review of clinical records for resident #019 indicated the resident has multiple diagnosis and is identified at high nutritional risk. The resident continues to receive mechanically altered diet.

Between a five week period resident #006's weight is noted to differ by 2.3 kg and there is no documented re-weigh completed. Between the following five week resident #006's

weight was noted to differ by 3.4 kg and there is no documented re-weigh completed.

During an interview on August 15, 2016, the RD confirmed to inspector #570 that resident #006 should have been re-weighed when his weight dropped in an identified month (-2.3 kg) and the following month (-3.4 kg).

Interviews with personal support workers (PSW) #112, 126 and 139 indicated to inspector #570 that re-weights are only completed when they receive directions from the RN or RPN.

Interviews with RPN #136 and # 138 indicated to inspector #570 that a re-weight is completed when there is 5 lbs (2.2 kg) difference in weight and the RN, RPN and dietitian determine if a re-weigh is needed.

On August 15, 2016 interview with the home's RD regarding her expectations when a resident's weight varies from the previous month. The RD indicated to inspector #570 the expectation is that if the resident's weight differs by 2 kg or more from the previous month's weight, then a re-weigh would be completed. The RD confirmed that re-weights are not done consistently and that she had to send lots of emails and notes to staff for residents to be reweighed as required by policy when there is weight variance of 2 kgs or more. [s. 68. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident.

Re: Log # 012140-16 for resident #046 & #047:

A CIR was submitted by the home on an identified date for an allegation of staff to resident physical abuse which occurred three days earlier. The CIR indicated that RPN #103 was providing treatment for an injury towards resident #046 & #047 and both residents reported they were sustained during provision of care by PSW #106. Resident #046 reported the PSW "is always so rough" and resident #047 reported "they forced me into this clothes".

Review of the home's investigation and interview of staff indicated the SDM's for both resident's were notified the day after the allegation was made. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's SDM and any other person

specified by the resident was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Re:Log # 009254-16 for resident #048:

A CIR was submitted by the home on an identified date indicating that five days earlier , resident #048 reported a complaint to the receptionist and Chief Executive Officer (CEO) that he/she had missed three baths and is rushed during the baths. An after hours call was received by the Director on the same date the resident reported the complaint to the CEO. The CIR indicated the resident's SDM was not notified until five days later. [s. 97. (1) (b)]

3. The licensee has failed to ensure the resident and resident SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Re: Log # 009254-16 for resident #048:

A CIR was submitted by the home on an identified date indicating that five days earlier, resident #048 reported a complaint to the receptionist and the CEO that he/she had not been provided baths during a specific month. The CIR indicated the investigation was completed 10 days later.

Interview of RN #120 indicated RN # 121 was completing the investigation into the allegation of neglect and no longer works in the home. RN #120 indicated there is no documented evidence the SDM was notified of the outcome of the investigation.

There was no documented evidence the SDM was notified of the results of the investigation.

Re: Log # 012140-16 for resident #046 & #047:

A CIR was submitted by the home on am identified date indicating that three days earlier, RPN #103 was providing treatment for an injury towards resident #046 & #047 and both residents reported they were sustained during care by PSW #106. Resident #046 reported the PSW "is always so rough" and resident #047 reported "they forced me into this clothes". An after hours call was received by the home on the date the residents reported sustaining injuries.The CIR was amended and indicated two PSW's were involved in the allegation (PSW #106 & #119). Both residents were re-interviewed the

following day and had no recall of the incident. The investigation concluded the allegations were unfounded. The CIR was completed by RN #120.

Review of the home's documentation indicated the investigation was completed on an identified date and the home was unable to determine if physical abuse occurred. There was no documented evidence the SDM's for resident #046 & #047 were notified of the results of the investigation.

Interview of RN #120 indicated there was no documentation to support the SDM's were notified after the investigation was completed. [s. 97. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident.

Re: Log # 009254-16 for resident #048:

A CIR was submitted by the home on an identified date indicating that five days earlier, resident #048 reported a complaint to the receptionist and the CEO about not receiving baths as indicated in the plan of care. The CIR indicated the home's investigation was completed and did not include the names of staff who were involved in the allegation of neglect.

Review of the home's investigation, interview of staff and review of the resident's health care record indicated the resident had missed nine baths in an identified month. The home's investigation identified five PSW's (#106, #132, #133, 134, #135). Those staff were not identified on the CIR. [s. 104. (1) 2.]

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA FRANCIS-ALLEN (552), BAIYE OROCK (624), CATHI KERR (641), KARYN WOOD (601), LYNDA BROWN (111), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2016_461552_0023
Log No. / Registre no:	002446-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 9, 2016
Licensee / Titulaire de permis :	St. Joseph's at Fleming 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 St. Joseph's at Fleming, you are hereby required to comply with the following order (s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee is hereby ordered to ensure that every medication incident has been reported to the resident, the resident's substitute (if any), the Director of Care, Medical Director, prescriber of the medication, the physician and/or Nurse Practitioner and pharmacy service provider under O. Reg. 79/10, s. 135 (1)

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Re: Log # 001592-16:

A Critical Incident Report was submitted by the home on an identified date for a medication incident that occurred the previous day. RPN #105 was observed in the home under the premise of picking up an item from a co-worker. The staff

member then stated to RPN #148 she would visit resident #044 before going home. RN #122 confirmed with RPN #148 that prior to RPN #105's visit with resident #044, the controlled substance was in place. RPN #148 again checked resident #044 once RPN # 105 had left and informed the RN the controlled substance was no longer in place. Resident #044 described to RPN #148 the person who had removed the controlled substance and the description fitted RPN #105.

Interview with RN #120 indicated after the incident that occurred, the RN reviewed all the missing controlled substances throughout the home and discovered over a 6 month period, there were 31 incidents of missing controlled substances. The RN confirmed that any missing controlled substance required a medication incident report completed. The RN indicated an email was sent to all home areas reminding registered nurses to complete this form and to check all residents using the controlled substance at the start of their shifts.. The RN confirmed that only 13/31 missing controlled substance incidents had a medication incident report completed which would indicate the resident had been assessed, incident reported to SDM, DOC, Medical Director and pharmacy.

Review of the 13 medication incident reports indicated the residents had no harm as a result. Only 11/13 had the SDM, DOC and physician notified. Only 2/13 reports indicated the pharmacy was notified.

A compliance order was issued as the scope demonstrated there were five different residents from various home areas involved in the incidences related to missing controlled substances.. The risk to the residents was high as they all received the controlled substance was used for treatment. The severity was high as there were 31 incidents of missing controlled substances but only13/31 had a medication incident report completed, 11/13 medication incident reports had the SDM, DOC and physician notified, only 3/13 reports indicated the pharmacy was notified.

In addition non-compliance has also been identified under WN #5 for O. Reg. 79/10. s. 107 (3) 3 for failing to notify the Director within one business day of a missing or unaccounted for controlled substance. The home was previously issued a Voluntary Plan of Correction (VPC) for O. Reg. 79/10. s. 107 (3) in February 2015 during inspection #2015_360111_0003.
(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee is hereby ordered to ensure that every medication incident related to a missing controlled substance or any other medications that bears a heightened risk of causing significant harm if used in error is subjected to an in-depth analysis, is documented and reported as required under O. Reg. 79/10, s. 135 (2)

Grounds / Motifs :

1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

Re: Critical Incident Log # 001592-16:

A Critical Incident Report was submitted by the home on an identified date for a medication incident that occurred the previous day. RPN #105 was observed in the home under the premise of picking up an item from a co-worker, The staff member told RPN #148 he/she would visit resident #044 before going home. RN #122 confirmed with RPN #148 that prior ro RPN #105's visit with resident #044, the controlled substance was in place. RPN #148 again checked resident #044 to see if the controlled substance was still in place and found it was no longer in place. Resident #044 described to RPN #148 the person who removed the

controlled substance and the description fitted RPN #105.

Review of the home's investigation, medication incident reports, interview of staff, and review of the pharmacy/home medication incident audits indicated:
-over a six month period there were 31 incidents of missing controlled substances involving five different residents (resident # 044, #060, #061, #062 & #063)
-only 13/31 missing controlled substance incidents had a medication incident report completed (despite an email reminder to nursing staff to complete the report and check for missing controlled substances).
- only 11/13 medication incident reports had the SDM, DOC and physician notified.
- only 3/31 missing controlled substances had documented evidence to indicate the pharmacy was notified.
-only one of the 31 missing controlled substance incidents was reported to the Director.
-after the Director was notified on an identified date of the missing controlled substance, additional action was not taken until approximately six weeks later (changing of exterior door codes) despite the home having awareness that RPN #105 was involved in the missing controlled substance. and still visiting the home.
-review of the Medication Incident audits (completed from pharmacy) indicated awareness of three incidents of missing controlled substances but no actions were identified to prevent a recurrence.
-review of the medication incident audits completed by the home indicated awareness of six incidents of missing controlled substances and no actions were identified to prevent a recurrence.

A compliance order was issued as the scope demonstrated there were five different residents involved in the missing controlled substances and they were located throughout the home. The risk to the residents was high as they all received the controlled substances for treatment. The severity was high as there were 31 incidents of missing controlled substances but only13/31 had a medication incident report completed, 11/13 medication incident reports had the SDM, DOC and physician notified, only 3/13 reports indicated the pharmacy was notified. In addition, only 1/31 incidents was reported to the Director (as identified under O.Reg. 79/10, s.107((3)3.

(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 9th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria Francis-Allen

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