Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2019	2018_641665_0011	025499-17	Complaint

Licensee/Titulaire de permis

Advent Health Care Corporation
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

Valleyview Residence
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 25, 26, 29, 30, November 1, 2, 6, 7 and 8, 2018.

The following complaint Log #025499-17 related to pain management, skin and wound and retaliation was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers (NM), Clinical Services Manager (CSM), Quality Improvement Coordinator (QIC), Resident and Family Relations Coordinator, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Worker (PSW) substitute decison-makers and family members.

During the course of the inspection, the inspector conducted resident care observations, reviewed residents' health records, reviewed education records and reviewed home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance to O.Reg.79/10, r. 30(1)(1), Every licensee of a long-term care home shall ensure that that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, the staff did not comply with the licensee's policy, "Pain Management policy #NMIIP010", last revised September 1, 2017.

A review of the home's Pain Management policy #NMIIP010, indicated under policy, that all residents will be screened for the presence of pain and pain is assessed; under documentation, the RN/RPN will document the pain assessment. Further review of a form titled, Online Assessments, provided by CSM #119, outlined that online assessments are to be completed and documented in Medecare. The form indicated that pain assessments are to be completed for new admissions, annually, quarterly and as needed/significant change.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Actionline on an identified date in 2017, regarding the care resident #001 received before

and after an identified procedure.

In an interview, the SDM indicated that they were notified by RN #112 on a specified date in 2017, that resident #001 had an area of altered skin integrity. On the following day, the SDM indicated that RN #112 informed them that the area of altered skin integrity had worsened. In the interview, the SDM stated that the resident appeared to be in pain.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity and that the resident was in a lot of pain.

A record review of the online assessments in Medecare indicated a pain assessment was not completed the day the NP #113 documented their progress note noted above.

In an interview, RN #112 indicated a pain assessment is completed for any area of altered skin integrity. The RN stated that resident #001's altered skin integrity had worsened the following day after discovery, but had overlooked completing the pain assessment for the resident. The RN indicated that it was important for the pain assessment to be completed to properly assess any pain and to manage the resident's pain. RN #112 acknowledged that the pain assessment for resident #001 was not completed, as per home's policy.

In an interview, NM #105 indicated that it is the home's policy for pain assessments to be completed by the registered staff to screen for the presence of pain. The NM acknowledged that RN #112 did not complete a pain assessment on the following day upon discovery of the altered skin integrity, for resident #001 as per the home's policy.

As a result of this identified non-compliance (NC), the sample was expanded to include residents #002 and #003.

A) A review of resident #002's electronic medication administration record (EMAR) for November 2018, indicated the resident had physician orders for a scheduled and as needed pain analgesic.

A review of resident #002's pain assessments in the online assessments in Medecare indicated quarterly pain assessments were not completed for one month in 2017 and two months in 2018.

B) A review of resident #003's EMAR for November 2018, indicated the resident had physician orders for two different types of pain analgesic, one scheduled and the other on as needed.

A review of resident #003's pain assessments in the online assessments in Medecare indicated quarterly pain assessments were not completed for two months in 2018.

In interviews, RN #117 and RPN #118, indicated that it is the home's policy for pain assessments to be completed in the online assessment in Medecare on a quarterly basis. Both registered staff reviewed residents #002 and #003's pain assessments in Medecare and indicated that the quarterly assessments noted above were not completed as per the home's policy.

In an interview, NM #105 indicated that it is the home's policy for pain assessments to be completed quarterly in the online assessments in Medecare. The NM reviewed the pain assessments for residents #002 and #003 and indicated that the staff did not follow the home's policy on the completion of quarterly pain assessments.

2. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was implemented.

In accordance to O.Reg.79/10, r. 30(1) (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the home's Pain Management policy #NMIIP010 with an effective date of September 1, 2017, included a form titled, "Description of Pain". The form outlined and described pain intensity as mild, moderate and horrible or excruciating. It also outlined how each pain intensity are manifested by the resident through facial expression (with pictorals), level of pain (scale of one to ten), body movement, behaviour, vocalization and physiological response.

In interviews, RNs #108, #111, #112, #114 and #117 and RPNs #109 and #118 indicated that the home has a pain management program. The registered staff stated that many residents in the home are unable to communicate pain and are cognitively impaired. The registered staff indicated that one of the resident home areas (RHA), had residents who were cognitively impaired and unable to communicate pain. RNs #108, #114 and #117 and RPNs #109 and #118 stated they have received training on the home's pain management policy through the home's online education in Surge Learning. When the registered staff were asked if the home had provided training on communication and assessment methods for residents who were unable to communicate their pain or who were cognitively impaired outlined in the Description of Pain form, the staff indicated they were not.

A review of the home's pain management education materials on Surge Learning provided by the QIC #115, indicated the home's Pain Management policy #NMIIP010; however, it did not include the Description of Pain as part of the training the registered staff received.

In an interview, NM #105 stated the home does not have an established pain management program. The NM reviewed the training materials in Surge Learning for the pain program and acknowledged that the home did not implement the Description of Pain form which was part of the home's pain management policy.

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

In accordance with O.Reg.79/10, s.30 (1)(1), the licensee was required to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: (1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the licensee's policy regarding "Skin and Wound Program – #NMIIS010vv", last revised September 5, 2017.

A review of Appendix A: Skin and Wound Care Overview, of the policy directed staff to identify residents at risk of altered skin integrity on admission, return from hospital, absence greater than 24 hours, quarterly and change in health status by completing a Braden Scale and Skin Assessment, identify the cause and implement interventions. Appendix C: Skin Assessment of the policy indicated that a head to toe skin assessment was to be completed upon any return from hospital.

A review of the home's form titled, Online Assessments, provided by CSM #119, outlined that online assessments are to be completed and documented in Medecare. The form indicated that head to toe assessments are to be completed on new admissions, annually, quarterly, as needed/significant change and readmission from hospital.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Actionline on an identified date in 2017, regarding the care resident #001 received before and after an identified procedure.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity. The resident was transferred to hospital for assessment, and returned to the home the same day with an identified diagnosis and discharge instructions.

Further review of the progress notes and clinical records indicated that the resident was transferred to hospital on three other occasions over a period of three days after the initial transfer to hospital noted above.

In interviews, RN #111 and #114 and RPN #109 indicated it is the home's policy to complete a head to toe skin assessment upon a resident's return from hospital in the online assessment in Medecare. RN #114 acknowledged they did not complete a head to toe skin assessment upon resident #001's return from hospital on an identified date in 2017.

In an interview, NM #105, who is the Skin and Wound Lead (SWL) for the home indicated it is the home's policy for a head to toe skin assessment be completed in Medecare when a resident returns from hospital. The NM reviewed the head to toe skin assessments in Medecare and indicated that the staff did not complete skin assessments for resident #001 upon their return from hospital on four identified dates in 2017.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Actionline on an identified date in 2017, regarding the care resident #001 received before and after an identified procedure.

In an interview, the SDM of resident #001 indicated they were not notified of the change in the resident's identified medication order after undergoing an identified procedure in hospital in 2017. The SDM stated they provided RN #111 with a prescription for the identified medication order upon the resident's return from hospital. The SDM indicated

that they were not notified that the medication order was changed.

A review of the physician orders indicated upon resident's return from hospital after the identified procedure, RN #111 confirmed the identified medication order with the physician at an identified time. Three hours and 45 minutes later, the identified medication order was changed.

Further review of the progress notes in Medecare did not locate documentation that the SDM was notified of the change in the medication order.

A review of the home's Hospital Transfer policy #NMIIH025 with an effective date of August 31, 2017, indicated when a resident is re-admitted from hospital, the RN/RPN will obtain consent for a new plan of care from the resident/substitute decision-maker.

In an interview, RN #111 indicated resident #001 returned from hospital after undergoing an identified procedure on an identified date in 2017. The RN indicated the SDM provided a prescription from hospital which included the identified medication order, and had confirmed the order with the physician. RN #111 further stated that the medication order was changed the same shift and they had confirmed the order with the physician. The RN confirmed that they did not notify the SDM of the change in the identified medication order.

In an interview, NM #105 indicated it is the home's expectation for residents' plan of care to be resident focused, multidisciplinary and to include input from the resident and/or the resident's family/SDM. The NM stated when a resident returns from hospital, the family/SDM is informed and consent is obtained for changes to the plan of care. NM #105 acknowledged that the home failed to ensure that the SDM of resident #001 was given an opportunity to participate fully in the development and implementation of the resident's plan of care, related to the change of the identified medication order for the resident.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

In an interview, the SDM indicated that they were notified by RN #112 on an identified date in 2017, that resident #001 had an area of altered skin integrity. The SDM indicated that the resident was transferred to hospital on four occasions over a five day period in

an identified month in 2017, related to the altered skin integrity of resident #001.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity. The resident was transferred to hospital for assessment, and returned to the home the same day with an identified diagnosis and discharge instructions.

Further review of the progress notes and clinical records indicated that the resident was transferred to hospital on three other occasions over a period of three days after the initial transfer to hospital noted above.

A review of the hospital transfer records from an identified hospital included identified recommendations and instructions for staff to manage the area of altered skin integrity for resident #001.

Review of the written plan of care effective at the time of the area of altered skin integrity, did not have documentation of the resident's area of altered skin integrity.

In interviews, RNs #112 and #114 indicated it is the home's expectation for the written plan of care to be updated when there are changes to the residents' status. The RNs stated that resident #001's written plan of care should have been revised to include the resident's altered skin integrity and the instructions from hospital.

In an interview, NM #105 indicated it is the home's expectation for the written plan of care to be updated with any changes in status. The NM reviewed the written plan of care for resident #001 and indicated that the resident's area of altered skin integrity and its interventions should have been documented in the plan of care. The NM acknowledged that the staff failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

3. In an interview, the SDM indicated that they were notified by RN #112 on a specified date in 2017, that resident #001 had an area of altered skin integrity. On the following day, the SDM indicated that RN #112 informed them that the area of altered skin integrity had worsened. In the interview, the SDM stated that the resident appeared to be in pain.

A record review of the progress notes in Medecare indicated that on the specified date in

2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity and the resident was in pain.

Review of the written plan of care effective at the time of the area of altered skin integrity, under pain/comfort/rest, did not have documentation on the resident's pain to the altered skin integrity.

In an interview, RPN #109 indicated that resident #001 was provided with an identified intervention to manage the resident's pain prior to the identified procedure the resident had undergone on an identified date in 2017.

In an interview, RN #111 indicated that upon resident #001's return from hospital after the identified procedure, the resident received an identified medication to manage their pain.

In interviews, RNs #112 and #114 indicated it is the home's expectation for the written plan of care to be updated when there are changes to the residents' status. The RNs stated that resident #001's written plan of care should have been revised to include pain and the interventions to manage the resident's pain to the area of altered skin integrity before and after the identified procedure.

In an interview, NM #105 indicated it is the home's expectation for the written plan of care to be updated with any changes in status. The NM reviewed the written plan of care for resident #001 and indicated that the resident's pain to the altered skin integrity and its interventions should have been documented in the plan of care. The NM acknowledged that the staff failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; and, to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview, the SDM indicated that they were notified by RN #112 on an identified date in 2017, that resident #001 had an area of altered skin integrity. On the following day, the SDM indicated that RN #112 informed them that the area of altered skin integrity had worsened.

In an interview, PSW #101 indicated they reported to RN #112 of resident #001's area of altered skin integrity on an identified date in 2017. On the following day, the PSW indicated that the area of altered skin integrity had worsened and had informed RN #112.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity. The resident was transferred to hospital for assessment, and returned to the home the same day with an identified diagnosis and discharge instructions.

Review of the online assessments in Medecare indicated that a head to toe skin assessment was not completed upon discovery of the area of altered skin integrity. The last documented head to toe skin assessment was 10 days prior to the discovery of the altered skin integrity.

In an interview, RN #112 indicated that a head to toe skin assessment is to be completed upon discovery of altered skin integrity. The RN reviewed the online assessments in Medecare and acknowledged that they did not complete the head to toe skin assessment for resident #001 upon discovery of the area of altered skin integrity.

In an interview, NM #105, who is the SWL indicated it is the home's process for a head to toe skin assessment be completed in Medecare upon discovery of altered skin integrity. The NM reviewed the head to toe skin assessments in Medecare and indicated RN #112 did not complete a skin assessment upon discovery of resident #001's area of altered skin integrity.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

In an interview, the complainants indicated they made two written complaints to the home's Administrator on two identified dates over a period of 13 days on a specified month in 2018, regarding care concerns of resident #001 and incidents of alleged retaliation.

The inspector asked the Administrator if they had received written complaints regarding resident #001, and the inspector was provided documentation of the complaints. A record review of the complaints indicated that the complainants sent two separate written complaints noted above to the Administrator via email.

In an interview, the Administrator indicated it is the home's process to forward written complaints to the MOHLTC. When asked if the two complaints received from the complainants were considered to be written complaints, the Administrator indicated both complaints were written complaints. The Administrator stated that both written complaints should have been forwarded to the MOHLTC. The Administrator acknowledged the home failed to ensure that written complaints were forwarded to the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: (1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the home's Pain Management policy #NMIIP010 with an effective date of

September 1, 2017, did not have a written description of the program which included its goals and objectives.

In an interview, NM #105 indicated that the home does not have an established pain management program. The NM stated that the pain management policy does not clearly direct the registered staff what to do in the pain management process.

In an interview, the Director of Care (DOC) indicated that the pain management program will be reviewed to ensure it meets legislative requirements. The home failed to ensure that the pain management program had a written description that included its goals and objectives.

2. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: (3) The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During a review of the home's annual evaluation of their pain management program, the QIC #115 provided the inspector the home's 2016 annual evaluation of their pain management program. When the inspector asked the QIC for the 2017, pain program evaluation, the QIC indicated they did not have the 2017 annual evaluation.

In an interview, the Administrator acknowledged the home did not conduct an annual evaluation of the pain management program for 2017. The Administrator indicated they have put processes in place to ensure program evaluations are completed in the home annually.

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

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Actionline on an identified date in 2017, regarding the care resident #001 received before and after an identified procedure.

In an interview, the SDM indicated that they were notified by RN #112 on a specified date in 2017, that resident #001 had an area of altered skin integrity. On the following day,

the SDM indicated that RN #112 informed them that the area of altered skin integrity had worsened. In the interview, the SDM stated that the resident appeared to be in pain.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity and that the resident was in a lot of pain.

A record review of the online assessments in Medecare indicated a pain assessment that was completed 10 days prior to the discovery of resident #001's altered skin integrity.

In an interview, RN #112 indicated that it is the home's process that a pain assessment is completed if a resident has an area altered skin integrity. The RN indicated that they conducted a pain assessment for resident #001's altered skin integrity upon discovery, and would have documented the assessment in the progress notes; however, upon the RN's review of the progress notes, the RN did not locate documentation of the pain assessment they completed. RN #112 acknowledged that the pain assessment for resident #001 was not documented.

In an interview, NM #105 indicated that pain assessments must be completed and documented by the registered staff to screen the presence of pain. The NM acknowledged that the pain assessment was not documented for resident #001 by RN #112.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response been made to the person who made the complaint, indicating: (i). what the licensee has done to resolve the complaint.

During an interview, the complainants alleged retaliation by staff. The complainants stated they had met with the previous DOC on two separate occasions; first on an identified date in 2017, regarding the home's management of resident #001's care before and after the resident's identified procedure; and secondly, four months later in 2018, regarding allegations of retaliation by staff. Six months later on two identified dates in the same month in 2018, the complainants indicated they had provided two separate written complaints to the Administrator, and had two meetings with the Administrator to discuss their complaints. As per the complainants, they were verbally provided a response to one of their 2018 written complaints above, during their meeting with the Administrator.

However, the complainants stated that they did not receive a follow up response from the home regarding their complaints made to the previous DOC in 2017 and 2018, and to the other written complaint in 2018.

The inspector requested documentation of the complaints made to the previous DOC, but the home was not able to provide documentation of the complaints, the investigation that was conducted or the follow up response to the complainants.

A review of one of the written complaint documentation indicated the Administrator and NM #105 met with the complainants nine days after the complaint was made.

In an interview, NM #105, indicated they were aware that the complainants met with the previous DOC the same month the complaint was made in 2017, noted above. The NM indicated that the previous DOC conducted an investigation to the concerns but was unable to confirm if a follow up response to the complainants was completed.

In an interview, the Administrator was aware that the complainant raised concerns regarding retaliation by staff with the previous DOC in an identified month in 2018. The Administrator indicated that they spoke to the previous DOC at the time, regarding the concern and an investigation was conducted by the previous DOC. The Administrator stated they were unaware if a follow up response was provided to the complainants. When asked if the home provided a follow up response for one of the written complaints in 2018, the Administrator indicated that a follow up response was not provided to the complainants as per the home's process. The Administrator acknowledged the home failed to ensure that for every verbal and written complaint, a follow up response was provided to the complainants related to resident #001.

2. The licensee has failed to ensure that a documented record was kept in the home that includes: (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response, and; (f) any response made by the complainant.

In an interview, the complainants stated they had met with the previous DOC on two separate occasions; first on an identified date in 2017, regarding the home's management of resident #001's care before and after the resident's identified procedure;

and secondly, four months later in 2018, regarding allegations of retaliation by staff. Six months later on two identified dates within the same month, the complainants indicated they had provided two separate written complaints to the Administrator, regarding care concerns related to resident #001 and incidents of alleged retaliation.

A review of the home's policy #ADM-07-035, titled, Concerns and Complaints with an effective date of January 2017, indicated under the heading of tracking on page two stated that minor and major complaints must be documented on the "Incident Notes" in Medecare if they are resident related; if they are non-resident related they should be documented on the JotForm Website.

A further review of the home's complaints policy, indicated another complaints policy titled Complaints, policy #ADMVII035vv, with an effective date of May 23, 2018. In an interview, the Administrator indicated that they had revised the previous Concerns and Complaints policy noted above in May 2018. The May 2018, policy on page three indicated there was a formal tracking of complaints using the complaint log in the home with quarterly review and analysis. On page five, the policy indicated that complaints are to be logged in the excel workbook for complaints.

A review of the resident #001's progress notes in Medecare did not locate documentation of the two complaints made to the previous DOC, as per the home's policy #ADM-07-035. The inspector requested to review the JotForm Website where non-resident related complaints were documented; however, the QIC #115 indicated that there were no documented complaints in the website for 2017 and 2018.

In interviews, NMs #104 and #105, indicated that complaints were tracked in a log in the home's shared drive. Both NMs indicated that they were aware of the complaints made to the previous DOC by the family of resident #001, and the previous DOC conducted the investigation. The NMs indicated they were not able to find documentation regarding the complaints. NM #104 who had been a NM for 10 years indicated the complaint log had not been used to document complaints until just recently.

A review of the complaints log for the period of two identified months in 2018, indicated the two written complaints in 2018, were not logged and documented.

The Administrator provided the inspector documentation regarding the two written complaints in 2018. A review of the two written complaints did not include the dates of any actions that had taken place, time frames for further actions to be taken, any follow-

up action required and the final resolution.

In an interview, the Administrator indicated they had worked in the home for about six months. The Administrator was aware that the complainants had made complaints to the home on an identified date in 2017 and four months later in 2018. The Administrator indicated that the complainants raised concerns regarding retaliation by staff with the previous DOC in 2018, and recently six months later on an identified date in 2018. The Administrator stated that they had spoken to the previous DOC in 2018, regarding the concern and an investigation was conducted by the previous DOC. When asked for documentation and investigation of the two complaints made by the family of resident #001 to the prvious DOC, the Administrator was not able to provide the inspector any documentation. In the interview, the Administrator indicated they had revised the Complaints policy in May 2018, as they discovered that the management staff had not been tracking complaints. When asked how the complaints were being documented, the Administrator stated that the management staff had recently started to log and document complaints in the home's excel file. The Administrator acknowledged that the home failed to ensure that a documented record was kept in the home that included: (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response, and; (f) any response made by the complainant for all four complaints in 2017 and 2018.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training shall be provided to all staff who provide direct care to residents: (4) Pain management, including pain recognition of specific and non-specific signs of pain.

A review of the home's Pain Management policy #NMIIP010 with an effective date of September 1, 2017, included a form titled, "Description of Pain". The form outlined and described pain intensity as mild, moderate and horrible or excruciating. It also outlined how each pain intensity is manifested by the resident through facial expression (with pictorals), level of pain (scale of one to ten), body movement, behaviour, vocalization and physiological response.

A review of the home's pain management education records for 2017, indicated the registered staff above received training on pain management. In an interview, QIC #115 indicated the registered staff receives training on the home's pain management policy in Surge Learning annually. The QIC provided the inspector with the training materials contained in their annual pain management education for direct care staff in Surge Learning. A review of the training materials was the home's pain management policy #NMIIP010 with an effective date of September 1, 2017; however, the policy did not include the Description of Pain form as part of the training the registered staff received.

In interviews, RNs #108, #111, #112, #114 and #117 and RPNs #109 and #118 indicated the home has a pain management program. The registered staff stated that many residents in the home are unable to communicate pain and are cognitively impaired. The RNs and RPNs noted above indicated that one of the resident RHA, had residents who were cognitively impaired and unable to communicate pain. RNs #108, #114 and #117 and RPNs #109 and #118 stated they have received training on the home's pain management policy through the home's online education in Surge Learning. When the registered staff noted above were asked if the home had provided training on communication and assessment methods for residents who were unable to communicate their pain or who were cognitively impaired as outlined in the Description of Pain form, they indicated they were not aware of any communication and assessment methods to assess pain. RN #108 indicated that the pain management policy in Surge Learning did not include communication and assessment methods to assess pain for residents who are cognitively impaired.

In an interview, NM #105 stated that the home's pain management policy does not

clearly direct the registered staff as to the assessment required for residents who are cognitively impaired and or unable to communicate their pain. The NM indicated that the annual training the registered staff receive through Surge Learning is the home's policy, which did not include assessment and communication methods for residents who were unable to communicate their pain and who were cognitively impaired. The NM acknowledged that the Description of Pain forms was not included in the annual training for the pain management program. The NM stated that the Description of Pain form provided information on specific and non-specific signs of pain and was a communication and assessment method for those residents were unable to communicate their pain and who were cognitively impaired.

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) :	JOY IERACI (665)
Inspection No. / No de l'inspection :	2018_641665_0011
Log No. / No de registre :	025499-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 11, 2019
Licensee / Titulaire de permis :	Advent Health Care Corporation 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
LTC Home / Foyer de SLD :	Valleyview Residence 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

To Advent Health Care Corporation, 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

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

Order / Ordre :

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

Specifically the licensee must:

1) Ensure resident #001 and all other residents are screened for pain by completing a pain assessment in the home's Medecare online assessments when resident #001 and all other residents have a significant change in status and/or as required as per the home's policy.

2) Ensure residents #002 and #003, and all other residents have quarterly pain assessments completed in the home's Medecare online assessments as per the home's policy.

3) Develop an on-going auditing process to ensure that pain assessments are completed in the online assessments in Medecare for residents #001, #002 and #003 and all other residents as per the home's policy. The home is required to maintain a documentation record of the audits, including the residents' names, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Grounds / Motifs :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place

any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance to O.Reg.79/10, r. 30(1)(1), Every licensee of a long-term care home shall ensure that that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, the staff did not comply with the licensee's policy, "Pain Management policy #NMIIP010", last revised September 1, 2017.

A review of the home's Pain Management policy #NMIIP010, indicated under policy, that all residents will be screened for the presence of pain and pain is assessed; under documentation, the RN/RPN will document the pain assessment. Further review of a form titled, Online Assessments, provided by CSM #119, outlined that online assessments are to be completed and documented in Medecare. The form indicated that pain assessments are to be completed for new admissions, annually, quarterly and as needed/significant change.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the Actionline on an identified date in 2017, regarding the care resident #001 received before and after an identified procedure.

In an interview, the SDM indicated that they were notified by RN #112 on a specified date in 2017, that resident #001 had an area of altered skin integrity. On the following day, the SDM indicated that RN #112 informed them that the area of altered skin integrity had worsened. In the interview, the SDM stated that the resident appeared to be in pain.

A record review of the progress notes in Medecare indicated that on the specified date in 2017, RN #112 documented that the assigned PSW reported resident #001's area of altered skin integrity. Another progress note the following day by NP #113 indicated the status of the altered skin integrity and

that the resident was in a lot of pain.

A record review of the online assessments in Medecare indicated a pain assessment was not completed the day the NP #113 documented their progress note noted above.

In an interview, RN #112 indicated a pain assessment is completed for any area of altered skin integrity. The RN stated that resident #001's altered skin integrity had worsened the following day after discovery, but had overlooked completing the pain assessment for the resident. The RN indicated that it was important for the pain assessment to be completed to properly assess any pain and to manage the resident's pain. RN #112 acknowledged that the pain assessment for resident #001 was not completed, as per home's policy.

In an interview, NM #105 indicated that it is the home's policy for pain assessments to be completed by the registered staff to screen for the presence of pain. The NM acknowledged that RN #112 did not complete a pain assessment on the following day upon discovery of the altered skin integrity, for resident #001 as per the home's policy.

As a result of this identified non-compliance (NC), the sample was expanded to include residents #002 and #003.

A) A review of resident #002's electronic medication administration record (EMAR) for November 2018, indicated the resident had physician orders for a scheduled and as needed pain analgesic.

A review of resident #002's pain assessments in the online assessments in Medecare indicated quarterly pain assessments were not completed for one month in 2017 and two months in 2018.

B) A review of resident #003's EMAR for November 2018, indicated the resident had physician orders for two different types of pain analgesic, one scheduled and the other when needed.

A review of resident #003's pain assessments in the online assessments in Medecare indicated quarterly pain assessments were not completed for two

months in 2018.

In interviews, RN #117 and RPN #118, indicated that it is the home's policy for pain assessments to be completed in the online assessment in Medecare on a quarterly basis. Both registered staff reviewed residents #002 and #003's pain assessments in Medecare and indicated that the quarterly assessments noted above were not completed as per the home's policy.

In an interview, NM #105 indicated that it is the home's policy for pain assessments to be completed quarterly in the online assessments in Medecare. The NM reviewed the pain assessments for residents #002 and #003 and indicated that the staff did not follow the home's policy on the completion of quarterly pain assessments.

The severity of this issue was determined to be a level 1 as there was minimum risk to the residents. The scope of the issue was a level 3 as it related to all three residents that were reviewed. The home had a level 3 history of one or more related NC in the last 36 months that included:
- Written notifications (WN) issued October 31, 2016, (2016_378116_0012) and January 16, 2018, (2017_631210_0021).

(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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