Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ Registre no	Type of Inspection / Genre d’inspection
Sep 22, 2015;	2015_30610a_0013 (A1)	H-002978-15	Resident Quality Inspection

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street St. Catharines ON L2N 4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street St. Catharines ON L2N 4J4

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

IRENE SCHMIDT (510a) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié
Grounds for order #1 were revised to be consistent with wording in licensee report.

Issued on this 29 day of October 2015 (A1)

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

Original report signed by the inspector.

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 le Loi de 2007 les foyers de soins de longue durée

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

IRENE SCHMIDT (510a) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 5,6,7,11,12,13,14,17,18,19, 2015

During the RQI, follow up on past due orders log #018350-15 (H-001230-14), #018351-15 (H-002933-15), #019272-15 (H-002980-15), #019273-15 (H-002981-15), #019276-15 (H-002982-15), #019279-15 (H-002983-15), #019280-15 (H-002984-15); CI's #2960-000004-15, 2960-000008-15, 2960-000011-14 and complaint #021807-15 (H-003096-15), were inspected.

During the course of the inspection, the inspector(s) spoke with residents, family members, Director of Care (DOC), Assistant Director of Care Manager (ADOC), Resident Assessment Inventory (RAI) Coordinator, Food Services Manager (FSM), Maintenance Manager, Manager, Life Enrichment (MLS), registered dietitian (RD), registered nursing staff, personal support workers, maintenance staff and dietary aides.

The following Inspection Protocols were used during this inspection:

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

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

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

16 WN(s)
8 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #003	2015_205129_0003	510a
O.Reg 79/10 s. 110. (7)	CO #005	2015_205129_0003	510a
O.Reg 79/10 s. 111. (2)	CO #004	2015_205129_0003	510a
O.Reg 79/10 s. 26. (3)	CO #002	2015_205129_0003	510a
LTCHA, 2007 s. 33. (3)	CO #001	2015_205129_0003	146

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 LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Policy #N-06.50, dated April, 2011, and titled Zero Tolerance of Abuse and Neglect Policy, directed that:
a) immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that resulted in physical injury or pain to a resident, the home would notify the resident's Substitute Decision Maker (SDM), and any other person the resident specified.
b) clinical staff responsible for care of the resident (Registered Nurse) harmed by the abuse or neglect shall conduct a head to toe physical assessment on the alleged victim and document findings if physical abuse was alleged and if necessary, contact physician or other health practitioners for further assessment, treatment and follow-up, based on nursing assessment of injury, pain or suspected injury such as wounds, fractures or head injury. Clinical staff would also document and communicate the status of the resident’s health condition, further assessments arranged, and health investigation findings to the manager/administrator.
c) The supervisor, manager, or Registered Nurse (RN) receiving the report of alleged abuse or neglect, would notify the Director of Care or designate immediately upon receipt of alleged, witnessed or unwitnessed abuse or neglect and initiate the investigation.

A review of the progress notes for an identified resident on an specified date outlined an allegation of physical abuse by staff. The note was transcribed by the registered staff, stating that the Personal Support Worker (PSW) reported to registered staff that the resident was complaining of discomfort during the night. In conversation with PSW, the resident alleged staff to resident physical abuse.
a) The licensee was made aware of the allegation on a specified date. However, as confirmed with the DOC, the home did not notify the residents' SDM right away.
b) No further documentation or action to assess the resident took place as confirmed with the registered staff on an identified date.
c) As confirmed on a specified date, the nurse who wrote the progress note, did not notify the DOC at the time of the alleged abuse.[s. 20. (1)] (156) [s. 20. (1)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).**

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were offered a minimum of a snack in the afternoon and evening.

Afternoon (PM) snacks were not consistently offered throughout the inspection.
On a specified date, an identified resident was observed to not receive a snack. The resident was noted to be on a minced textured diet. When the inspector interviewed the resident, they reported that a snack was not offered.
On an specified date, front line staff confirmed that those on a pureed textured diet were not offered a snack in the afternoon. The Food Services Manager (FSM) confirmed that those on a pureed textured diet would only receive a pureed textured snack if they had a labeled snack prepared. A copy of the labels provided to the inspector were compared with the resident diet lists. None of the 14 residents noted to be on a pureed textured diet were listed to receive a labeled pureed snack for afternoon or evening. As confirmed with the FSM, residents on a pureed textured diet were not offered or provided snacks in the afternoon and evening.
On a specified date, residents in an identified area were not offered a snack in the afternoon. The afternoon snack cart was observed and no snack was available on the cart as confirmed with the PSW. On another identified area, there was snack available for regular textured diets. However, no pureed textured snack was available.
Residents were not offered a minimum of a snack in the afternoon and evening. [s. 71. (3) (c)]

2. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

During the lunch meal observation on a specified date, the posted menu on two identified areas indicated that yellow beans were to be provided. In both areas, peas were served instead.
Throughout the inspection, the home did not follow the therapeutic snack menu. The menu in one area was dated, and indicated that a variety of cookies were to be available for regular diets for the pm snack daily. As well, pureed fruit or pudding cups were to be available for those on a pureed textured diet. The planned menu items were not offered or available at the pm snack as the menu was not followed for those residents on a pureed textured diet, as confirmed with the FSM. [s. 71. (4)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

An identified resident was admitted to the home on a specified date. Admission skin assessment completed by registered nursing staff on that date noted 'skin clear and intact'. Admission assessments completed by the dietitian on two later specified dates, noted the resident had altered skin integrity in an identified area. Registered nursing staff first recorded altered skin integrity in this area in progress notes on another specified date, and subsequently completed a wound assessment on a later date, which confirmed the presence of the identified alteration in skin integrity. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. s. 6. (4) (a) [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change.

An identified resident was hospitalized on a specific date and returned to the home on specific date. On a later specified date, two middle rails were observed in the up position for the identified resident and on another specified date, the resident's bed was observed to have one middle rail and one upper assist rail, in the up position. The resident reported that they used the rails to help mobilize in and out of bed. Review of the documents the home referred to as the care plan and the kardex, both directed that the resident did not have side rails engaged. Registered staff reported the side rails were implemented for the identified resident on their return from hospital. The ADOC confirmed the care plan for the specified resident had not been updated when their condition changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff and others involved in the different aspects of care of the resident:
1) collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
2)the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

The following was observed on a specified date:
i) a random check of first floor revealed that the windows in specified resident rooms,opened to approximately 45 centimetres (cm.)
ii) on the second floor the windows in one specified resident room opened up to 45 cm.
iii) the home confirmed that all the identified windows opened to 45 cm.

The ADOC and DOC confirmed that the windows were not in compliance. The home mitigated the immediate risk by closing and locking the windows and removing the cranks. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents, can not be opened more than 15 centimetres, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

According to the health record, on a specified date, at a specified time, an identified resident was in the shower room with a PSW. The resident had shoes on and was asked by the PSW to stand to be transferred from the shower chair. However, the floor was wet and the resident fell, with no injury. Both the RPN and the DOC confirmed that the transfer was done improperly and against home policy and should not have been attempted on a wet floor. The home's policy N-12.10 entitled "Preparing for resident transfer and/or reposition" indicated that staff should be sure that there were no spills on floor. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: 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 to ensure that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) 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.

A) On a specific date, an identified resident returned from hospital. A skin assessment was completed on return which reported two areas of bruising, as well as a surgical incision in an identified area. On a later specified date, the progress notes indicated it had been reported that the resident had altered skin integrity in two additional identified locations. A physician order directing that the additional areas of altered skin integrity be monitored and pressure relieved, was received and added to the treatment administration record on the same day. The treatment was discontinued as of specific date. Review of the clinical record revealed the absence of a skin assessment between the resident's return from hospital and discontinuation of the treatment. This was confirmed by the Assistant Director of Care (ADOC). A skin assessment, using a clinically appropriate assessment instrument, was not completed by registered staff for the identified resident when they exhibited altered skin integrity.
B) An identified resident was admitted to the home on an identified date. Admission skin assessment noted skin clear and intact. Admission dietitian notes on identified dates reported the resident had altered skin integrity in an identified area. Progress notes on a specific date noted the resident had altered skin integrity at a specific site. A wound assessment with a later specified date, was the first assessment related to the alteration in skin integrity that had been identified in the progress notes. Policy N-11.01, and titled Skin and Wound Care Program, directed that registered staff would, "upon discovery of a pressure ulcer, initiate a baseline assessment using a clinically appropriate assessment instrument (on PCC/Wound Assessment)". The first assessment related to the alteration in skin integrity identified in the progress notes on a specific date, was completed on a later specified date. 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 was not completed for the identified resident when an alteration in skin integrity was identified.510) [s. 50. (2) (b) (i)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 #7: 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 failed to ensure that the programs included height upon admission and annually thereafter.

As confirmed with the RD and DOC on a specified date, residents did not have heights taken on an annual basis.
a) An identified resident had a height taken on an specified date and another height had not been taken since.
b) An identified resident had a height taken on a specified date and another height had not been taken since.
c) An identified resident had a height taken on a specified date and another height had not been taken since. [s. 68. (2) (c)]

2. The licensee failed to ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

A) An identified resident was admitted on a specific date with a 'reported' admission weight. The nutritional assessment completed by the RD noted that the weight was reported and not actually taken in the home. Progress notes on the same date, written by the RD, also indicated that an admission weight was required. The ADOC confirmed that the clinical record did not support that a weight had been measured in the home on admission.
B) An identified resident was admitted on a specified date with a 'reported' admission weight. The nutritional assessment completed on an identified resident by the RD noted that the weight was reported and not actually taken in the home. Progress notes written by the RD also indicated that an admission weight on site was required. The ADOC confirmed that the clinical record did not support that a weight had been measured in the home on admission. (156) [s. 68. (2) (e) (i)]

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 programs include:
1) a height measurement upon admission and annually , and
2) a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

A) An identified resident had a reported admission weight. The recorded weight the following month represented a weight change of 5.2% over one month. The weight change was not assessed using an interdisciplinary approach. As well, actions were not taken and outcomes were not evaluated, as confirmed with the RD on a specified date.
B) An identified resident was admitted with a reported admission weight. The following month, the recorded weight represented a weight change of 23% of body weight over one month. An assessment on the weight change was not found in the clinical record or action taken and outcomes evaluated, as confirmed with the ADOC on August 11/15. (156) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

As confirmed with the DOC on an identified date, the home had not trained all staff on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities. Registered staff confirmed on a specific date that they had not received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, when hired.
The DOC confirmed that several contracted staff, as well as volunteers in the home, had not been trained on the home policy to promote zero tolerance of abuse and neglect of residents as of an identified date. [s. 76. (2) 3.]

2. The licensee failed to ensure that all staff had received retraining annually related to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

As confirmed with the DOC and ADOC as of an identified date, 13% of activation staff, 82% of dietary staff, 75% of janitorial staff, 60% of laundry staff, 15% of psw staff, and 27% of registered staff had not received annual retraining on the policy to promote zero tolerance of abuse and neglect of residents as outlined above. Since brought to the attention of the home, 100% of registered and psw staff had completed the retraining on 'surge learning' and the home was in the process of completing retraining for the remaining staff. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and that all staff have receive retraining annually related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.

WN #10: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

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:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

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:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, 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: 1. Falls prevention and management.

The DOC and ADOC confirmed that falls prevention and management training had not been completed by direct care giving staff in the past year. [s. 221. (1) 1.]

2. The licensee has failed to ensure that for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices was provided. O. Reg. 79/10, s. 221 (1).

The home produced documentation which indicated that: 15.4 % of registered staff had not completed training on restraints within the past year; and that 9.8% of direct care staff had not completed training on restraints within the past year. This information was confirmed by the DOC and ADOC. [s. 221. (1) 5.]

3. The licensee has failed to ensure that training was provided to all staff who provide direct care to residents: 6. For staff who apply Personal Assistance Safety Devices (PASDs) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

The home produced documentation which indicated that 15.4 % of registered staff had not completed training on PASDs within the past year; and that 9.8% of direct care staff had not completed training on PASD's within the past year. This information was confirmed by the DOC and ADOC. [s. 221. (1) 6.]

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 training is provided to all staff who provide direct care to residents, in falls prevention and management, the application, use and potential dangers of physical devices (restraints) and in the application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

A) On an specified date, two middle rails were observed in the up position for an identified resident. On another specified date, the resident's bed was observed to have one middle rail and one upper assist rail in the up position. Review of the clinical record revealed the absence of a bed rail assessment for the identified resident. Registered staff and the ADOC confirmed a bed rail assessment had not been completed for the resident when bed rails were implemented.
B) On specified dates, two upper rails were observed in the up position for an identified resident. The care plan and kardex directed use of bed rails for safety. Review of the clinical record revealed the absence of a bed rail assessment for the resident. The ADOC confirmed a bedrail assessment had not been completed for the resident when bed rails were implemented. (510)
C) On specified dates, two upper rails were observed in the up position for an identified resident. The care plan and kardex directed use of bed rails for safety. Review of the clinical record revealed the absence of a bed rail assessment for the resident. The ADOC confirmed a bed rail assessment had not been completed for the resident when bed rails were implemented. (510) [s. 15. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

An identified resident, according to the health record, experienced falls without injury on specific dates. Post fall assessments were not completed after the falls, as confirmed by the ADOC and the DOC. [s. 49. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that since there was no Family Council established in the home, that they, on an on-going basis, advised families and persons of importance to residents of their right to establish a Family Council.

As confirmed with the DOC, the home could not provide evidence of attempts to establish a Family Council or how they communicated with families and persons of importance to residents to their right to establish a Family Council. [s. 59. (7) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and the Family Council, if any, is sought, in developing and carrying out the survey. 2007, c. 8, s. 85. (3).

During an interview, an identified resident reported that the advice of resident's council was not sought in developing and carrying out the satisfaction survey. Review of Resident Council minutes revealed no evidence that consultation with Resident's Council, in developing and carrying out the satisfaction survey, occurred. This was confirmed by the Manager, Life Enrichment (MLE). [s. 85. (3)]

2. The licensee has failed to ensure that (a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice.

During an interview, an identified resident reported that the satisfaction survey results were not made available to Resident's Council in order to seek the advice of Council about the survey. Review of Resident Council minutes revealed no evidence that the results were presented to Council or that Council's advice about the survey, was sought. This was confirmed by the Manager, Life Enrichment (MLE). [s. 85. (4) (a)]

WN #15: 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. (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 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

A complaint was made to the home in reference to an identified resident. As confirmed with the DOC, the home had not kept a written record of the complaint received, the date it was received, any actions taken to resolve the complaint or final resolution.
The DOC confirmed that a complaint log was not kept by the home to document any complaints. [s. 101. (2)]

WN #16: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).

A) An identified resident sustained a fall with injury on a specific date. After the resident returned from hospital, an amendment to the critical incident (CI) report submitted to the Director by the home on an identified date, was requested, with specific direction to include any falls prevention and management strategies in place prior to the most recent fall and specific interventions that would be implemented upon resident's return to facility. On an identified date, the DOC confirmed the amendment to the CI had not been submitted and analysis and follow up action related to a critical incident was not provided.
B) An identified resident sustained a fall with injury on an identified date. After the resident returned from hospital, an amendment to the CI submitted to the director by the home on a specific date, was requested, with specific direction to include, among other things, falls prevention and management strategies in place prior to the fall and specific interventions that would be implemented upon the resident's return to the facility. On an identified date, the DOC confirmed the amendment to the CI had not been submitted and analysis and follow up action related to a critical incident was not provided. [s. 107. (4) 4.]

Issued on this 29 day of October 2015 (A1)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : IRENE SCHMIDT (510a) - (A1)

Inspection No. / No de l'inspection : 2015_30610a_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-002978-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 22, 2015;(A1)

Licensee / Titulaire de permis : BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street, St. Catharines, ON, L2N-4J4

LTC Home / Foyer de SLD : HEIDEHOF LONG TERM CARE HOME
600 Lake Street, St. Catharines, ON, L2N-4J4

Name of Administrator / Nom de l’administratrice ou de l’administrateur : ELENA CADDIS

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall ensure that, in the event that registered staff become aware of an alleged, suspected or actual incident of abuse or neglect of a resident, they shall:
1) conduct a head to toe physical assessment on the alleged victim and document findings if physical abuse was alleged
2) if necessary, contact physician or other health practitioners for further assessment, treatment and follow-up, based on nursing assessment of injury, pain or suspected injury such as wounds, fractures or head injury
3) document and communicate the status of the resident health condition, further assessments arranged, and health investigation findings to the manager administrator.
4) notify the resident s substitute decision maker (SDM) as directed by policy.

Grounds / Motifs :

(A1)
1. Policy #N-06.50, dated April, 2011, and titled Zero Tolerance of Abuse and Neglect Policy, directed that:
a) immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that resulted in physical injury or pain to a resident, the home would notify the resident s Substitute Decision Maker (SDM), and any other person the resident specified.
b) clinical staff responsible for care of the resident (Registered Nurse) harmed by the abuse or neglect shall conduct a head to toe physical assessment on the alleged victim and document findings if physical abuse was alleged and if necessary, contact physician or other health practitioners for further assessment, treatment and follow-up, based on nursing assessment of injury, pain or suspected injury such as wounds, fractures or head injury. Clinical staff would also document and communicate the status of the resident's health condition, further assessments arranged, and health investigation findings to the manager administrator.
c) The supervisor, manager, or Registered Nurse (RN) receiving the report of alleged abuse or neglect, would notify the Director of Care or designate immediately upon receipt of alleged, witnessed or unwitnessed abuse or neglect and initiate the investigation.

A review of the progress notes for resident #020 dated February 2015 outlined an allegation of physical abuse by staff. The note was transcribed by the night RN as "Personal Support Worker (PSW) reported to writer that resident complained of pain in shoulder. PSW proceeded to ask if resident wanted pain meds and they refused. Resident stated that they did not want the medicantions.

a) The licensee was made aware of the allegation on August 2015. However, as confirmed with the DOC, the home had not notified the residents' SDM as of August 2015.
b) No further documentation or action to assess the resident took place as confirmed with the RN on August 2015.
c) As confirmed on August 2015, the RN who wrote the progress note, did not notify the DOC at the time of the alleged abuse.[s. 20. (1)] (156) [s. 20. (1)] (156)

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

Oct 09, 2015

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. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that:
1) afternoon and evening snacks are prepared and offered to all residents in the home, including residents receiving modified texture diets, and
2) a process is in place to ensure staff have access to modified texture snacks for residents, as necessary.

Grounds / Motifs :

1. Afternoon (PM) snacks were not consistently offered throughout the inspection .
On an identified date, a snack was not observed being offered to an identified resident. The resident was noted to be on a minced textured diet. When the inspector interviewed the resident, they reported that a snack was not offered.
On a specific date, front line staff confirmed that those on a pureed textured diet were not offered a snack in the afternoon. The Food Services Manager (FSM) confirmed that those on a pureed textured diet would only receive a pureed textured snack if they had a labelled snack prepared. A copy of the labels were provided to the inspector and compared with the resident diet lists. None of the 14 residents noted to be on a pureed textured diet were listed to receive a labelled pureed snack for pm or hs. As confirmed with the FSM, residents on a pureed textured diet were not offered or provided snacks in the afternoon and evening.
On a specific date, residents on a specific floor were not offered a snack in the afternoon. The pm snack cart was observed and no snack was available on the cart as confirmed with the PSW. On another floor, there was snack available for regular textured diets, however, no pureed textured snack was available.
Residents were not offered a minimum of a snack in the afternoon and evening.
(156)

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

Oct 09, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee shall ensure that in all resident home areas:
1) the planned menu items are offered and available at each meal, and
2) the therapeutic snack menu is followed, with planned menu items for residents on modified texture diets, being offered and available at each snack.

Grounds / Motifs :

1. During a lunch meal observation, the posted menu on specific floors indicated that yellow beans were to be provided. On both floors, peas were served instead. Throughout the inspection, the home did not follow the therapeutic snack menu. The menu on the floors indicated that a variety of cookies were to be available for regular diets for the afternoon snack daily. As well, pureed fruit or pudding cups were to be available for those on a pureed textured diet. The planned menu items were not offered or available at the afternoon snack as the menu was not followed for those residents on a pureed textured diet. (156)

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

Oct 09, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 29 day of October 2015 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : IRENE SCHMIDT - (A1)

Service Area Office / Bureau régional de services : Hamilton