Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, Nov 18, 2014	2014_306510_0021	H-001102-14	Resident Quality Inspection

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

IRENE PASEL (510), KELLY HAYES (583), ROSEANNE WESTERN (508), VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 18, 19, 20, 21, 25, 26, 27, 28, 29, 2014

During this RQI, Critical Incidents #H-001104-14 and #H-000219-14 were inspected.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Coordinator Environmental and Food Services, RAI Co-ordinator, Director Therapeutic Recreation, Resident Care Coordinator, Dietician, personal support workers (PSW), registered nursing staff, dietary staff, housekeeping staff, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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:
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 failed to ensure that all staff who apply physical devices or who monitor residents restrained by a physical device were trained on the application, use and potential danger of these physical devices. A review of the Edgewater Gardens annual education 2014 materials, showed that staff who apply physical devices where trained on restraints but this training did not include the application of physical devices, the use of physical devices or the potential danger of these physical devices. In an interview with the Administrator/Director of Care it was confirmed that staff were not trained in those areas. [s. 221. (1) 5.]

2. The licensee has failed to ensure that training was provided for all staff who applied personal assistance services device (PASD)s or who monitored residents with PASDs including the application, use and potential dangers of these PASDs.
In an interview with registered nursing staff on August 21, 2014 it was shared that they did not know what a PASD was. A review of Edgewater Gardens Annual Education 2014 material showed that education was not provided on PASDs. In an interview with the Administrator/Director of Care on August 26, 2014 it was confirmed that the annual and new Hire education did not include PASD education. It was confirmed that staff were not trained on the application, use and potential dangers of PASDs. [s. 221. (1) 6.]

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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when developing the restraint plan of care for identified residents, the following were satisfied:
1. There was significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained.
2. Alternatives to restraining the resident had been considered and tried where appropriate but would not have been effective to address the identified risk.
3. The method of restraining was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable methods that would be effective to address the risk.
4. The restraining of the resident was consented to by the resident.

A) It was identified by the Inspector on August 21, 2014 at 1530 hours, that an identified resident had been restrained with a seat belt and a table top. A review of the clinical records indicated that the resident's restraints initially ordered and applied in 2007, had not been reassessed.
It was confirmed by the registered staff that the resident's restraints had not been reassessed.
B) During an observation and an interview with staff, it was identified that two identified residents had seat belt restraints while up in their wheelchairs. A review of the clinical records for these residents indicated that the residents had not been assessed, alternatives to restraining these residents had not been considered and there were no consents for the resident's restraints. This was confirmed by registered staff and the Administrator. [s. 31. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was reviewed and revised when an identified resident's needs changed.

An identified resident had a procedure completed in hospital and returned to the home later that day. The resident was ordered a medication to manage the post procedure pain. The resident complained of abdominal pain on identified dates. The clinical records indicated that the resident was not reassessed and the plan of care was not reviewed and revised.
It was confirmed by registered staff that the identified resident had not been reassessed and the plan of care was not reviewed and revised when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #4: 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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is (b) complied with.

A) An identified resident had a procedure done in hospital and returned to the home the later that day. The resident was experiencing pain in [redacted] abdomen due to the procedure and was prescribed a new medication for pain management.

The home's pain policy titled, Pain Management Protocols, directs staff to conduct pain screening quarterly and when pain is indicated through verbal complaints. It also directs staff to complete a new pain assessment when a resident has new pain and when new medications are ordered for pain control.

A review of the clinical records indicated that the identified resident was experiencing new pain from the procedure and complained of pain to staff on identified dates. Staff were administering a new medication for pain control. Staff did not complete a pain screening or a pain assessment as directed in their policy.
It was confirmed by the Administrator that staff did not follow the Pain Management Protocols to assess the identified resident's pain. (508) [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system, instituted or otherwise put in place is (a) in compliance with and is implemented in accordance with applicable requirements under the Act.

A) Policy #N-26-110 titled "Pressure Ulcer Prevention" directs the home's Skin and Wound Program. This was confirmed by the Administrator/Director of Care (DOC). The home's policy does not require that residents at risk of altered skin integrity are assessed upon any return of the resident from hospital and/or an absence of more than 24 hours, as required in the regulations. The homes skin and wound program is not in compliance with applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (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 be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

There was damage to wooden doors at entry to the first floor care area as well as to wooden handrails in care areas on levels one and two of the home. The administrator confirmed the damage and advised it is difficult to maintain wooden structures with motorized mobility devices.
The SPA room on level one had walls chipped and base boards falling off leaving holes in the wall. As well, the surface of the over bed table used to hold towels was damaged, leaving exposed particle board.
The SPA room on level two was observed to have tiles missing and walls in disrepair.
The Edgewater Gardens workplace inspection recording form dated January 2014 identified maintenance hazards in both the first and second floor SPA rooms. Under action taken, it is documented that all issues are awaiting renovation date.
The Administrator confirmed the noted disrepair and that there is no confirmed renovation date. The administrator agreed that while awaiting renovations, repairs are required. [s. 15. (2) (c)]

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 be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of abuse of a resident that the licensee knew of, or that was reported was immediately investigated.

A review of an identified resident's plan of care showed that the resident alleged, on an identified date, that they were abused. Staff completed documentation in the progress notes on identified dates explaining that the resident had alleged they had been abused in the home. In an interview with the Administrator/Director of Care it was shared that they were aware that the identified resident voiced concerns related to alleged abuse. It was confirmed with the Administrator/Director of Care on an identified date that the reported alleged abuse was not immediately investigated and that an investigation did not take place. [s. 23. (1) (a)]

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 be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff were using all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

It was observed by the inspector on an identified date, that the tub chair lifts in the first and second floor tub rooms did not have the required lap belts. According to the manufacturers' instructions for the chair lift, residents were to be secured using the chair lifts lap belts. Staff indicated that the lap belts had been removed and that they did not use the lap belts while operating the chair lift.
It was confirmed by staff and the Administrator that the lap belts had been removed from the chair lifts and were not being used while residents were in the chair. [s. 23.]

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 be implemented voluntarily.

WN #8: 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 did not use a clinically appropriate assessment instrument specifically designed for falls.

On an identified date, an identified resident fell and sustained a fracture. The resident was transferred to the hospital, assessed, and transferred back to the home where they were provided palliative care and died on an identified date. The resident had experienced a previous fall. Both falls were assessed using the home's Internal Incident Report however there was not documentation to indicate a post-fall assessment was completed using a clinically appropriate assessment instrument. A member of the registered nursing staff confirmed that the home continues to use the paper copy form and does not have an assessment specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when an identified resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

An identified resident had pain related to a chronic disease and was prescribed a routine medication, and a "when necessary" (PRN) medication for pain management. A review of the resident's clinical records indicated that the resident had complained of pain and requested the PRN medication in addition to the regularly prescribed medication many times during an identified time frame. Staff conducted two pain assessments; however, the resident was not reassessed when the resident's pain was not relieved.
It was confirmed by registered staff that the identified resident was not assessed using a clinically appropriate instrument when their pain was not relieved by initial interventions. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menus were communicated to the residents.

In an interview with an identified resident it was shared that the weekly menu was not always posted. The resident's family bring in outside food based on a review of the weekly menu and the resident's preferences. On an identified date and time, it was observed that the week three weekly menu was posted on the menu board. It was confirmed with the Director of Environmental Services and Nutrition that the correct weekly menu for the identified week was the week four weekly menu. [s. 73. (1) 1.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A) On an identified date, an identified resident was observed being fed lunch in a wheel chair in tilt position and coughing periodically throughout the meal. On another identified date, the same resident was observed being fed lunch in a wheel chair in tilt position and leaning to the left side. The Inspector requested the registered staff to observe the identified resident. The staff confirmed that the resident was being fed in tilt position, with poor body alignment. A review of the plan of care showed that the identified resident was a total assist with feeding and required a modified texture diet.

B) On an identified date, an identified resident was observed being fed lunch in a wheel chair in tilt position and coughing periodically throughout the meal. On another date, the same resident was observed being fed in a wheel chair in tilt position. The inspector requested the staff to observe the resident. The staff confirmed the resident was being fed in tilt position. A review of the plan of care showed that the identified resident was a total assist with feeding and required a modified texture diet, modified fluid consistency and was at choking risk due to swallowing difficulties.

In an interview with the Administrator/Director of Care and RAI-MDS Coordinator on an identified date, it was shared that the annual education provided to staff, directed staff that 1) residents should not be fed in tilt position, 2) residents should be repositioned in their chair if required and 3) positioning aids should be used if required for alignment. The A/DOC and RAI-MDS Coordinator confirmed the identified residents were not fed using safe positioning techniques. [s. 73. (1) 10.]

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 be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

The Food Service/Environmental Coordinator (FSEC) advised that the the hospital maintenance department provides the Home's preventative maintenance program. This was confirmed by the Administrator/Director of Care (DOC). The FSEC provided a copy of the Edgewater Gardens Workplace Inspection Form, dated January 2014 which included observed hazards in the first and second floor SPA rooms. Requisitions had been issued for two of the four identified hazards. Under action taken, all four areas indicated 'all issues awaiting renovation date'. A tour of the building on identified dates revealed walls were in disrepair in the SPA rooms on levels one and two. The state of disrepair was confirmed by the Administrator/DOC who advised there was a plan for renovations to this area. There was no date identified for the renovations. There is no schedule in place for routine, preventive and remedial maintenance. [s. 90. (1) (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 be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the "Restraint" policy (N-16-40) January 31, 2006, last reviewed January 2014 addressed how the use of restraining would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Regulations.

In an interview with the Administrator/Director of Care it was confirmed that the homes restraint policy did not address how the use of restraints would be evaluated. [s. 109. (g)]

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 be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a PASD described in subsection (1), used to assist a resident with with a routine activity of living was used only if the personal assistance services device (PASD) was included included in the residents plan of care.

A) On an identified date, an identified resident was observed sitting in a wheel chair in tilt position. A review of the electronic and paper plan of care showed that direction for tilt positioning was not found in the identified resident's plan of care. In an interview with the registered nursing staff it was shared that the resident used a tilt wheelchair for positioning and comfort and that it was considered a PASD that limited the resident's movement. The registered nursing staff confirmed the tilt wheel chair was not included in the resident plan of care.

B) On an identified date, an identified resident was observed sitting in a wheel chair in tilt position. A review of the electronic and paper plan of care showed that direction for tilt positioning was not found in the identified resident's plan of care. In an interview with the registered nursing staff it was shared that the resident used a tilt wheelchair for positioning and comfort and that it was considered a PASD that limited their movement. The registered nursing staff confirmed the tilt wheel chair was not included in the identified resident's plan of care. [s. 33. (3)]

WN #14: 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 (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.

A) MDS for an identified resident reported the resident had a stage one pressure ulcer. Review of Point Click Care (PCC) documentation revealed there were no skin assessments completed.
Review of the hard copy clinical record revealed no skin assessments had been completed.

B) Review of Minimum Data Set (MDS) revealed that an identified resident had a stage two ulcer. Subsequent MDS assessments also reported the presence of ulcers. Review of electronic and hard copy clinical records revealed the absence of weekly skin assessments using a clinically appropriate assessment instrument.

Resident Assessment Inventory (RAI) Coordinator confirmed the absence of skin assessments using a clinically appropriate assessment instrument for the identified residents. The Administrator/Director of Care (DOC) confirmed the absence of a clinically appropriate assessment instrument for skin and wound assessment. [s. 50. (2) (b) (i)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Clinical records for an identified resident indicated the resident experienced bladder incontinence. Staff confirmed that the resident is incontinent of urine.
The Director of Care was unable to provide a continence care and bowel management program.
Review of the clinical record in Point Click Care (PCC) revealed no continence assessment was completed at or since admission for the identified resident.
Review of the hard copy clinical record revealed the absence of any continence assessment.
The Resident Assessment Instrument (RAI) coordinator confirmed the absence of any continence assessment. [s. 51. (2) (a)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

President of the Resident's council reported they receive feedback from management to any questions/concerns they raise at a subsequent Resident Council meeting. Review of the Resident's Council minutes revealed written responses to written resident inquiries/suggestions are signed off as received by resident council president, at the time of the next meeting. The Administrator/Director of Care confirmed that although he provides a written response to the staff facilitator with in ten days, the resident's council does not receive the response until the next meeting, the following month. The licensee does not respond in writing to Resident's Council within 10 days. [s. 57. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that on an ongoing basis they advised families and persons of importance to the residents of their right to establish a Family Council.

In an interview with the Administrator/Director of Care (A/DOC) and the Director of Therapeutic Recreation (DOTR) staff stated that the home does not have an established family council. It was confirmed with the A/DOC and DOTR that families and persons of importance to the residents are not advised on an ongoing basis of their right to establish a family council. (583) [s. 59. (7) (a)]

2. The licensee has failed to ensure that semi-annual meetings convened that advised residents' families and persons of importance to residents of their right to establish a family council.

On an identified date, the Administrator/Director of Care and the Director of Therapeutic Recreation stated there was not a family council established at the home. It was confirmed during the interview that a semi-annual meeting did not take place to advise residents' families and persons of importance to residents of their right to establish a family council. [s. 59. (7) (b)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (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).

Resident Council president reported they are unaware of the results of the satisfaction survey.
Administrator/Director of Care (DOC) reported this years satisfaction survey has not yet been completed and results are not ready to be shared. He was unaware of the results of last years satisfaction survey and was unable to provide documentation that would demonstrate the results of the survey were made available to resident's council. [s. 85. (4) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident's SDM was notified within 12 hours upon becoming aware of any alleged incident of abuse by the resident.

A review of an identified resident's plan of care showed that the resident alleged they were abused. Staff completed documentation in the progress notes on identified dates explaining that the identified resident had alleged they had been abused in the home. In an interview with the Administrator/Director of Care, on an identified date it was shared that they were aware that the identified resident voiced concerns related to alleged abuse. It was confirmed with the A/DOC that the resident's substitute decision maker (SDM) was not notified within 12 hours of becoming aware of the identified resident's reported alleged abuse and that the SDM had not yet been notified. [s. 97. (1) (b)]

WN #20: 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 is 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

During this inspection, it was identified that the home did not keep a documented record of complaints which included all of the requirements listed in r.101(2).
An interview with the Administrator confirmed that the home did not keep a documented record of the complaints they had received. [s. 101. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).
2. The resident's obligation to pay the basic accommodation charge as described in subsection 91 (3) of the Act. O. Reg. 79/10, s. 224 (1).
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year. O. Reg. 79/10, s. 224 (1).
5. A list of the charges that a licensee is prohibited from charging a resident under subsection 91 (1) of the Act. O. Reg. 79/10, s. 224 (1).
6. The list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services. O. Reg. 79/10, s. 224 (1).
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at the time of admission the home provided a package with all of the required information to every resident and to their substitute decision-maker(SDM), if any.

A review of the Admission Process checklist indicated that the home does not provide residents and their SDM (if any), all of the required information when they are admitted to the home.
The package provided to residents and their SDM at the time of admission did not include the following:

A) An explanation of a person's duty to make mandatory reports to the Director.

B) Statement that residents are not required to purchase care, services, programs or goods from the home, and may purchase such things from other providers, subject to any restrictions by the licensee with respect to the supply of drugs.

It was confirmed by the Administrator that the admission package does not include all of the required information to be provided to the residents and their SDM at the time of admission. [s. 224. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that they had developed and implemented a quality improvement (QI) and utilization review system required under section 84 of the Act complying with the following requirements.

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdiscplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O.Reg 79/10, s 228.

During an interview with the Administrator, it was identified that the home had not developed and implemented a quality improvement and utilization review system. [s. 228. 1.]

Issued on this 31st day of December, 2014

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

Irene Rosel

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IRENE PASEL (510), KELLY HAYES (583), ROSEANNE WESTERN (508), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2014_306510_0021
Log No. / Registre no:	H-001102-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 21, Nov 18, 2014
Licensee / Titulaire de permis :	HALDIMAND WAR MEMORIAL HOSPITAL 206 JOHN STREET, DUNNVILLE, ON, N1A-2P7
LTC Home / Foyer de SLD :	EDGEWATER GARDENS LONG TERM CARE CENTRE 428 BROAD STREET WEST, DUNNVILLE, ON, N1A-1T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KATE RICHARDSON

To HALDIMAND WAR MEMORIAL HOSPITAL, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
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.
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).

Order / Ordre :

The licensee shall:

1. develop and implement a training program for staff who apply physical devices that includes the application of physical devices, the use of physical devices or the potential danger of these physical devices.
2. ensure that education is provided to all staff on personal assistive safety devices. In addition, the licensee will ensure this education is included in the new hire orientation education and ongoing annual staff education at Edgewater Gardens.

Grounds / Motifs :

1. A) A review of the Edgewater Gardens annual education 2014 materials, showed that staff who apply physical devices where trained on restraints but this training did not include the application of physical devices, the use of physical devices or the potential danger of these physical devices. In an interview with the Administrator/Director of Care it was confirmed that staff were not trained in the those areas.

B) In an interview with registered nursing staff on an identified date it was shared that they did not know what a Personal Assistance Services Device (PASD) was. A review of Edgewater Gardens Annual Education 2014 material showed that education was not provided on PASDs. In an interview with the Administrator/Director of Care on an identified date it was confirmed that the annual and new Hire education did not include PASD education. It was confirmed that staff were not trained on the application, use and potential dangers of PASDs.

(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that when developing the restraint plan of care for the identified residents, the following are satisfied.

1. There is significant risk that the resident or another person would suffer serious bodily harm if the resident is not restrained.
2. Alternatives to restraining the resident are considered and tried where appropriate but would not have been effective to address the identified risk.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk.
4. The restraining of the resident is consented to by the resident.

Grounds / Motifs :

1. During an observation and an interview with staff, it was identified that the identified residents had restraints. A review of the clinical records for these residents indicated that the residents had not been assessed, alternatives to restraining these residents had not been considered and there were no consents for the resident's restraints. This was confirmed by registered staff and the Administrator. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Irene Pasel

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