Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 30, Sep 4, 5, 6, 7, 2012	2012_092203_0034	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0

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

CARMEN PRIESTER (203), MARIAN MACDONALD (137), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Regional Manager,the Corporate Nurse Consultant,the Corporate Nutrition Manager, the RAI Coordinator, the Nutrition Manager, the Registered Dietitian, the Corporate Dietitian, the Maintenance Manager, the Activities Coordinator, the physiotherapist, the Restorative Care Coordinator, the hairdresser,8 Registered Staff, the Resident Council representative, the Family Council representative, 22 Personal Support Workers, 30 residents, and 5 family members.

During the course of the inspection, the inspector(s) reviewed clinical records, spoke with residents and families, interviewed staff, observed resident care, reviewed policies and procedures. observed meal and snack service, observed medication administration, reviewed admission and resident charges records, reviewed staffing schedules, reviewed minutes of meetings pertaining to the inspection, toured resident care areas and service areas of the Home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

A review of three residents' clinical records revealed documented evidence that they were at risk for falls. Further review revealed that their Falls Risk Assessments were not current.

A review of the Risk Management Report revealed that an identified resident sustained multiple falls in less than one year. There is no documented evidence that a Post Fall Assessment was completed for 50% of the incidents.

Another identified resident has sustained multiple falls. There is no documented evidence that a Safety Plan-Post Fall Assessment was conducted for 75% of the falls. This was confirmed by the Director of Care.

The care plan for two identified residents revealed that they had interventions in place to prevent falls. These residents were observed to not have these the identified interventions in place. The absence of the interventions was confirmed by the resident and a member of the nursing staff.

There was no documented evidence of a Falls Prevention and Management Committee, no post-falls analysis and no interventions developed/implemented to mitigate the risk for falls or to reduce the incidents of falls. This was confirmed by the Director of Care, in the presence of the Corporate Nursing Consultant.{O.Reg.79/10,s.49(1)

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 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.

Findings/Faits saillants :

Windows openings were measured in 15 resident rooms throughout the home and 12/15 (80%) of the windows were observed to open more than 15 centimeters. The windows opened from 16.5 cm to 30.5 cm and one opened 61 centimetres. The Regional Manager and Administrator were immediately made aware. [O.Reg. 79/10,s.16]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

It was observed that the linen cart was blocking the emergency exit by the pop machine in a resident care area.
The emergency exit at the end of a resident care area was noted to be blocked with a portable privacy screen.
The fire hose cabinet in a resident care area was observed to be blocked by a wheelchair.
Two nursing inspectors observed 2 kitchen doors propped by 5 gallon containers of chemical, allowing resident access directly to the kitchen with no staff in attendance. All 3 ovens were on at 350 degrees, scissors observed on counter, and utility knife and screw drivers were in a plastic container on the counter. There was a knife holder secured to the wall containing 11 sharp knives of various sizes.
[LTCHA2007,S.O.2007,c.8,s.5]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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

Findings/Faits saillants :

An identified resident has sustained several falls within the last year.
There is no documented evidence that a Falls Risk Assessment for this resident has been completed in this period of time.

A review of the Risk Management Report revealed that an another identified resident sustained several falls in the last year. The last Falls Risk Assessment was completed more than one year ago.
[LTCHA2007,S.O.2007,c.8,s.6(10)(b)]

A review of the Risk Management Report and residents progress notes revealed that a specified resident sustained numerous falls in the last nine months. The last documented Falls Risk Assessment was completed more than eighteen months ago.[LTCHA2007,S.O.2007,c.8,s.6((11)(b)]

A review of the plan of care for two identified residents reveal interventions identified to prevent falls. Upon observation these intervention were not in place and this was confirmed by the resident and a staff member.

A review of the plan of care for an identified resident revealed no documented evidence that the resident had a medical device. The MDS assessment indicates the resident uses a medical device and a staff member confirmed that there is a medical device in use for this resident.

The care plan for a specified resident has inaccurate interventions for toileting. Two staff confirm that the interventions on the care plan do not reflect the care that the resident requires or is provided. [LTCHA2007,S.O.2007,c.8,s.6(1)(c)]

A review of CCAC admission information for an identified resident reveals a diagnosis that could not be located in the medical diagnosis or in the plan of care. The Registered staff confirmed that they are not aware of the diagnosis.
[LTCHA2007,S.O.2007,c.8,s.6(1)(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 ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, and that if the plan of care is revised because care set out in the plan has not been effective, the licensee has ensured that different approaches are considered in the revision of the plan, 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 :

The following was noted during the inspection:
Stained ceiling tiles at the end of resident hall.
Lounge chairs have the finish worn off on the legs.
Baseboard heater in the large dining room was broken with the cover hanging off.
Wall in the large dining room near the exit door was damaged.
Nursing station laminate damaged and chipped.
Bottom of the Emergency exit door was damaged.
There were large holes in the lower wall in the hallways in one resident area.
There were many areas of chipped paint, baseboards missing,holes that had been patched but not painted.
Handrails, doors and walls throughout the home were noted to be damaged and in need of repair.
Hand rails are rough in places and could cause slivers.
Water on the floor in two tub rooms.
Water on the floor by the pop machine for two days that was being soaked up by towels. LTCHA2007,S.O.2007,c.8,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 ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

The Administrator and Regional Manager confirm that the plans for improvement, the accountability for the improvement plan, and the planned deadline for completion are components of the Quality Improvement plan and that they are not in place at this time.

The Quality Improvement program has not been fully developed and implemented.

The Infection Control Program was evaluated in May 2012: There are areas identified for improvement but no formal plan developed with accountability and dates for improvement.

Resident Safety Plan and Falls Prevention Program were evaluated March 31, 2011. This evaluation notes shortfalls but no formal plan or accountability for improvement.

Behavioral Program was evaluated in April 2012: The evaluation notes the progress of this team but no formal plan for improvement.

Quality Improvement Program was evaluated July 21, 2012. The planning and implementation dates are missing. [LTCHA2007,S.O.,c.8,s.84]

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 quality improvement and utilization review system analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to the residents of the long term care home, to be implemented voluntarily.

WN #7: 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 subsections:

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

Findings/Faits saillants :

Orientation and Training Program evaluated in May 1, 2011 but no plans were developed for negative responses, or dates of planned implementation established.

Abuse Prevention Program was evaluated in June 2011 but has no plans for the negative responses or dates of planned implementation.

The required Falls Prevention Program has not been developed. Post falls assessments have not been consistently completed, and there has been no Falls training provided to the staff. The Falls Risk Assessments are not current. The home has experienced a significant number of falls since June 2011 without analysis, and interventions have not been implemented to mitigate risk and reduce falls.

Continence: The home has not followed their policy re Bladder and Bowel Management Program. They have not completed Continence Assessments as per their policy. This was confirmed by the Nurse Consultant and Director of Care. A nursing staff who is a member of the Committee confirms that the they met July 2, 2012 (evidenced in minutes) and prior to that they had not met since January 2012.

Skin and wound: There is no Skin and Wound interdisciplinary committee as per the home's policy. This was confirmed by Director of Care.

The Home's Bladder and Bowel Management Program policy states, "the interdisciplinary team will complete the Caressant Care Continence Assessment on all residents who score a 2 or higher on a specific section of the assessment tool or at any time upon resident change of status". An identified resident's assessment confirmed that this criteria was met but a Caressant Care Continence Assessment was not completed, as per the homes policy.

Another identified resident's assessment indicates that the resident met the policy's criteria but has not had a continence assessment in over one year.

A review of the Safety Plan - Resident Policy, dated March 2012, indicates that "a safety plan is to be developed by the interdisciplinary team in conjunction with each resident, the resident's SDM and any other person designated by the resident or SDM in order to address the resident's individualized assessed needs". There is no documented evidence of an interdisciplinary team in place related to Falls Prevention and Management, and this was confirmed by the Director of Care.

A review of the interdisciplinary Skin Care Management Team policy (March 2007) indicates that "the team will be comprised of the Skin Care Coordinator, RN or RPN, Food Nutrition Manager, dietitian (as required) and Personal Support Worker, and they will meet monthly and minutes recorded". There is no documented evidence that an interdisciplinary Skin and Wound Care Management Team is in place and this was confirmed by the Director of Care and RPN.[O.Reg.79/10,s8(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 ensure that policies are in compliance with and are implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The shower chairs in two tub rooms had a black residue/mold or mildew embedded in the mesh (around the stitching). Black residue was also noted around the base of the shower. Corporate Regional Manager confirmed the presence of the black substance.

There was feces on the floor of the shower.

A specified resident confirmed that the bathroom is always dirty and that there are lingering odors.

Two tub rooms had floor drains caked with debris and were noted to have a small amount of water pooling on the floor.

Another tub room was noted to have a black substance noted around the base of the shower as well as on the back of the mesh shower chairs.[O.Reg.79/10,s.87,2(b)]

There were lingering offensive odors in many of the bathrooms in two out of three resident care areas.

Raised toilet seats in the bathrooms in two out of three resident areas were soiled.[O.Reg 79/10,s.87(2)(d)]

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 procedures are developed and implemented for cleaning and disinfection of resident care equipment, supplies and devices and contact surfaces, and for addressing incidents of lingering offensive odors, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The tub room in a resident care area was found unlocked, door propped open and a wet floor sign in front of the door. Upon entry to the tub room a resident was found inside the room, unsupervised. There was a bottle of disinfectant in the room. A staff member confirmed that the practice was to leave the tub room door propped open during lunch hour, in case a resident needed to use the bathroom. This was reported to the Administrator and Regional Manager immediately.

During the initial tour of the home, the tub room in one resident area was not locked. It was noted to contain disinfectant cleaner. This was reported to the Administrator.

The door to a tub room in another resident area was not locked allowing immediate access. Disinfectant cleaner and a 4 litre bottle of tub cleaner were observed in the unlocked room. This was brought to the attention of the Regional Manager.

On another date the door to a tub room was not locked allowing access to the room. There was disinfectant observed in a spray bottle inside the room.

During the initial tour of the home, the door to the kitchen was observed to be propped open with a 5 gallon pail of sanitizer. There was no staff in attendance and there were three containers of chemicals on the floor under the sink, as well as a closet door open and the closet contained chemicals. There were unattended residents in a dining room servery and there was a spray bottle of disinfectant in a cupboard that was not locked.
[O.Reg79/10,s.91]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

5/14 resident charts reviewed have not had a quarterly drug review since March 2012. This was confirmed by Corporate Nurse Consultant. [O.Reg.79/10,s.134(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 ensure that there is at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

There was no resident-staff communication and response system available in any lounges or any of the dining rooms. This was verified by the Administrator. [O.Reg.79/10,s.17(1)(e)]

It was identified in three resident rooms that the call bell could not be activated from the bedside. This was confirmed in the presence of the Director of Care. [O.Reg.79/10,s.17(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 ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, and is on at all times., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

Of the current residents residing in the home, 294 residents sustained falls between June 2, 2011 and August 20, 2012. Of current and discharged residents, there were 476 falls between June 2, 2011 and August 20, 2012.
A review of the Risk Management report revealed that there were 178 falls between January 1,2012 and August 20, 2012. There was no documented evidence that the Program includes protocols to monitor outcomes and to minimize falls. This was confirmed by the Director of Care.
[O.Reg.79/10,s.30(1)1]

Evaluation of Programs for Falls, Continence, Skin and Wound and Pain Program Program have not occurred in the last year. These Programs have not been updated in the last year. The Administrator confirms these have not been completed.[O.Reg.70/10,s.30(1)3]

The Program evaluations that have been completed identify shortfalls but do not include the summary of changes made and the dates the changes were implemented. [O.Reg.79/10,s.30(1)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 there is a written description of each organized program required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation and that this description includes its goals and objectives and relevant policies, procedures and protocols, and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, that the program is evaluated and updated at least annually, and that a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #13: 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 subsections:

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).

Findings/Faits saillants :

Training related to continence care and bowel management for direct care staff was last provided in July 2011 with 16/58 nursing staff attending. This was confirmed by 2 nursing staff and by the Director of Care.[O.Reg.79/10,s.221(1)3]

A review of staff training records revealed that staff were not provided training in falls prevention and management. This was confirmed by the Administrator and two Personal Support Workers.[O.Reg.79/10,s.221(1)1]

A review of staff training records revealed that there is no documented evidence that direct care staff are provided training in skin and wound care. This was confirmed by the Administrator, two Registered staff and two Personal Support Workers. [O.Reg79/10,s.221.(1)2]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that training regarding continence care and bowel management is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #14: 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 :

There are no implementation dates for improvement identified in any of the Program evaluations that were completed. The persons that participated in the evaluation of the Program were not identified on the evaluations. This was confirmed by the Administrator and the Corporate Regional Manager. [O.Reg.97/10,s.228.4(ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the quality improvement and utilization review system's record include the names of the persons who participated in evaluations, and the dates improvements were implemented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The Director of Care stated that residents have their own individual nail clippers that are kept in labeled, individual drawers in each tub room. It was noted that an identified shower room had only 6 pairs of nail clippers for 32 residents. Another tub room had only 5 pairs of nail clippers for 20 residents. Another tub room had no nail clippers. There was one pair of rusty nail clippers on the edge of the sink that contained nail clippings. Direct care staff confirmed that residents are to have their own nail clippers that are kept in individual labeled drawers in each tub room. [O.Reg79/10,s.229(4)]

Four identified residents had not received their pneumococcus, diptheria and tetanus vaccinations at the time of admission. This was confirmed by the Director of Care. [O.Reg.79/10,s.229(10)3]

Five identified residents had not had Tuberculosis screening completed within 14 days of admission. [O.Reg.79/10,s.229 (10)1]

Director of Care/Infection Control Coordinator and the Nurse Consultant indicated that the home has the adopted the "Just Clean Your Hands" program. It was indicated that hand washing audits are completed. The audits were not available when requested. The Administrator confirmed that hand washing audits are not being completed. [O.Reg.79/10,s,229(9)]

Five out of seven (71%) employee files reviewed have not had tuberculosis screening. Administrator confirmed that they do not have TB screening for these five employees.[O.Reg.79/10,s.229(10)4]

During a lunch meal a staff member went from assisting one resident with fluids, to another table and fed two residents. The same staff member then went to assist another resident with fluids, at which time the resident spit out the cranberry juice onto the staff's hands. The staff member then returned to feeding other residents. Hand washing or the use of hand sanitizer was not carried out by this staff member.
Staff were also observed to be clearing dishes and then serving deserts without washing their hands or using hand sanitizer between clearing and serving of foods. [O.Reg79/10,s.229(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 all staff participate in the implementation of the infection control program, that there is a hand hygiene program in accordance with evidence-based practices, that every resident admitted to the home is screened for tuberculosis within 14 days of admission, that residents are offered immunization against pneumoccocus, tetanus and diptheria in accordance with with the publicly funded immunization schedules posted on the Ministry website,and that staff are screened for tuberculosis in accordance with evidence based practices, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following subsections:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services.
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home.
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency;
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency;
(c) conduct a planned evacuation at least once every three years; and
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

The home has not tested their emergency plan in relation to a situation involving a missing resident (code yellow) since September 2010.
The home had not tested their emergency plan in relation to medical emergencies (code blue) and violent outbursts (code white) on an annual basis. [O.Reg.79/10,s.230(7)(a)]

The home has not tested their emergency plans for community disasters/chemical spills (code orange), bomb threats (code black), hostage taking/intruder (code purple) once every three years. This was confirmed by the Administrator. [O.Reg.79/10,s.230(7)(b)]

The home does not have any plans for dealing with medical emergencies. They do refer to it as a code blue in the emergency plan however there is no procedure written on what to do in the event of a code blue-medical emergency. This was confirmed by the Administrator.[O.Reg.79/10s.230(4)1(v)]

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 their emergency plans provide for dealing with medical emergencies, and that the home shall test the emergency plans related to situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, and test all other emergency plans at least every three years, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following subsections:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

The home has not completed an annual evaluation of the effectiveness of the medication management system. This was confirmed by the Administrator and the Regional Manager. [O.Reg79/10,s.116(1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

Two identified residents are on routinely scheduled Benzodiazepines. The tablets were observed to be kept in the strip packages and not in a separate locked area within the medication cart.This was confirmed by the Registered Staff. [O.Reg.79/10,s.129(1)(b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

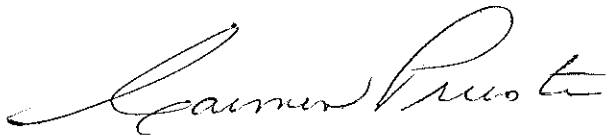
There was no evidence that the hot water holding tanks have been inspected. This is confirmed by the Administrator following her contacting the Corporate Head Office. [O.Reg79/10,s.90(2)(f)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #001	2011_023155_0025	203
O.Reg 79/10 r. 54.	CO #002	2011_023155_0025	203
O.Reg 79/10 r. 231.	CO #003	2011_023155_0025	203

Issued on this 11th day of September, 2012

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



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) :	CARMEN PRIESTER (203), MARIAN MACDONALD (137), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2012_092203_0034
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Aug 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 30, Sep 4, 5, 6, 7, 2012
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ARTHUR NURSING HOME 215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA CANADA

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Order / Ordre :

The Licensee is required to prepare, submit and implement a plan for achieving compliance with O.Reg 79/10,s.49(1)
Please submit the plan to Carmen Priester at London SAO.moh@ontario.ca quoting L-001269-12 by Sept 30, 2012

Grounds / Motifs :

1. A review of three residents' clinical records revealed documented evidence that they were at a risk for falls. Further review revealed that their Fall Risk Assessments were not current.

A review of the Risk Management Report revealed that an identified resident sustained multiple falls in less than one year. There is no documented evidence that a Post Fall Assessment was completed for 50% of the incidents.

An identified resident has sustained multiple falls. There is no documented evidence that a Safety Plan-Post Fall Assessment was conducted for 75% of the falls. This was confirmed by the Director of Care.

The care plan for two identified residents revealed that they had interventions in place to prevent falls. These residents were observed to not have the identified interventions in place. The absence of the interventions was confirmed by the resident and a member of the nursing staff.

There is no documented evidence of a Falls Prevention and Management Committee, no post falls analysis and no interventions developed/implemented to mitigate the risk for falls or to reduce the incidence of falls. This was confirmed by the Director of Care, in the presence of the Corporate Nursing Consultant. (137)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee is required to implement a plan for achieving compliance with O.Reg79/10,s.16 by Sept 21, 2012.

Grounds / Motifs :

1. Window openings were measured in 15 resident rooms throughout the home and 12/15 (80%) of the windows were observed to open more than 15 centimetres. The windows opened from 16.5cm to 30.5 cm and one opened 61 centimetres.
The Regional Manager and the Administrator were immediately made aware. (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 7th day of September, 2012

Signature of Inspector / Signature de l'inspecteur : Carmen Priester

Name of Inspector / Nom de l'inspecteur : Carmen Priester

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