Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2017	2017_600568_0015	029839-16, 032453-16, 033515-16, 005151-17	Complaint

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 LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH LISTOWEL ON N4W 2L1

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

DOROTHY GINTHER (568)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 26, 27, 28, 29, 30, 2017

IL- 48219-LO / log # 033515-16 related to retaliation;
IL- 49704-LO / log # 005151-17 and # 029839-16 related to responsive behaviours;
IL- 47920-LO / log # 032453-16 related to continence, improper care and safe and secure home were completed in conjunction with this inspection.
A Critical Incident inspection # 2017_600568_0016 was also conducted in conjunction with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Activities Director, Ward Clerk, RAI Coordinator, one maintenance staff, two Restorative Care Aides, two Registered Nurses, two Registered Practical Nurses, eleven Personal Support Workers, one contract Security Guard, residents and their families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **3 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. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to a resident using funding that the licensee

received from the local health integration network.

The Ministry of Health and Long-Term Care (MOHLTC) Funding Policy "LTCH Required Goods, Equipment, Supplies and Services", Date: July 1, 2010 (Funding Policy), part of the L-SAA agreement, provide that the Licensee cannot charge residents for continence management supplies.
The funding policy which is part of the L-SAA agreement, provides that:
The licensee must provide the following goods, equipment and services to long-term care home residents at no charge using the funding the licensee receives from the LHIN or accommodation charges received under the LTCHA.

The funding policy states, under 2.1.2 Continence Management Supplies: Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA.

Review of the Resident Information Sheets identified that six residents wore a specified continence product for incontinence.

a) Review of a resident's most recent MDS assessment identified that the resident was frequently incontinent of both bowel and bladder. The most recent continence assessment stated that the resident had occasional urge and overflow incontinence and used their own continence product.

During an interview with the identified resident they told the inspector that they needed assistance to use the washroom. When asked if the home had offered to provide them with the continence products, the resident said they wanted them to wear a different type of product but they found it very uncomfortable and difficult to manage. They preferred to use a specific continence product, and therefore family provided it.

The resident's substitute decision makers (SDMs) shared with this inspector that the home advised them that they did not provide the specified continence product for residents. If they wanted the resident to wear them, they were told they would have to purchase the product and keep a stock in the resident's room. The SDM said they were not told the reason that the home would not provide the specified product, but they assumed it was related to the budget.

b) Review of a resident's most recent MDS assessment identified that the resident was

usually continent of bladder and occasionally incontinent of bowel. The continence assessment documented that the resident had urge incontinence. The resident used their own continence products and was aware of the urge to void.

During an interview with a PSW they shared that the identified resident was usually continent of both bowel and bladder with occasional accidents and wore a specific continence product. When asked why the resident provided their own continence products the staff member said the home did not provide this type of product.

When speaking with the identified resident they told the inspector that they had become increasingly independent since they came to the home. The resident said that their family picked up their continence products and brought them in to the home. When asked if the home had offered to provide the products, the resident said “no". The resident said that they preferred this type of product because it was easier for them to manage.

During the course of the inspection three staff told the inspector that the home provided a range of continence products including different liners / pads and briefs in a variety of sizes. They all said that the home did not provide these specific continence products and if residents wished to have them used, their families would need to buy them and bring them in.

During a telephone interview with the Director of Care they shared that the home did not provide any other continence products other than what was shared by staff because of safety concerns. The DOC said that they advised families up front that they didn't provide these specific continence products. At the same time they educated them about the safety concern surrounding the use of the product. If they still wished to have them used then families were told they would need to purchase the specific product and bring them into the home. The DOC said that she was aware of several families that had been providing these specific continence products for their loved ones for some time.

The licensee failed to ensure that residents were not charged for continence products that a licensee was required to provide to a resident using funding received from the LHIN.

The severity was determined to be a level one with minimal harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. [s. 245. 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. 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,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During interviews with two Personal Support Workers (PSWs) they shared that each wing of the home had a continence product allowance bin for a particular shift. The bins were stocked by the night staff and they could pick them up when they first started their shift. The staff said that the bins contained one product change for each resident that was assessed as needing a continence product. Each cart had a Resident Information Sheet which identified the type of product each resident was to be given for each shift. Staff reported that if they required additional continence products the home's process was for the PSWs to first check the "buffer bin" kept behind the nursing desk. If the product was not available there then they must get a registered staff who had a key to the supply cupboard where more product was stored.

Two other PSW's told inspector #568 that they often ran out of continence products in their allowance bin during a shift. Essentially each resident had only one change, so if they were incontinent of bowel or bladder early in their shift then they would have no further changes available unless they used another resident's product. the PSW's said that sometimes residents were being left in a product because they didn't have another one easily accessible to change them. Many of the residents required more than one

product change per shift in order to remain clean and dry. The staff said that it took time to locate extra product, whether it be in the buffer bin or by finding a registered staff to unlock the storage cupboard. Depending if the registered staff was in the middle of a treatment or giving medication they may have to wait ten minutes to even get the product. During this time the residents' would be left to wait in a soiled or wet product and staff were not able to respond to other resident concerns.

PSW's said that sometimes they used a different product than what was identified for the resident in order to save the time of going to find the nurse, or in situations where the identified product was not available in the home. The staff said that often they ran out of a particular product so they would have to improvise with either a different product or size. Several staff said that they wished the Ministry of Health was in the home everyday because when they visited, the amount of continence product in their allowance bins increased.

During interviews with two registered staff they told inspector #568 that if the PSWs ran out of continence product in their allowance bins, they would first check the "buffer bin" located at the nursing desk. If the product was not available there then they would come to one of the registered staff who had a key to the room where extra product was kept. When asked if they always had the correct product available, both staff said that sometimes they ran out of a particular product and would have to substitute with another product or size. This would occur most often towards the end of the week. When asked how often staff came to them during a shift to ask for an extra product, they both said usually a couple of times but sometimes more or less often depending on the day. The registered staff said usually they were able to respond quickly to the staff request, but there were occasions where they had to wait if they were in the middle of a treatment or if they didn't have the keys.

Record review identified that the "Resident Information Sheets to Reflect Care Plan" identified that in total there were 36 incontinent residents. The worksheet for each wing of the home identified the resident, room number, and the type and number of continence product to be used for the resident on each shift. Of the 36 incontinent residents, only one resident was given an extra product change on one shift. The remaining residents were provided one product change in the allowance bin for an eight our time period.

Review of a resident's admission Minimum Data Set (MDS) assessment identified that the resident was frequently incontinent of urine and occasionally incontinent of bowel. The continence assessment stated that the resident had urge and overflow incontinence

and would need three to four incontinence products each day. The Resident Information Sheet had documented that the identified resident had one continence product in the allowance bin for each eight hour shift. During an interview with a Personal Support Worker and continence team member they said that when the resident was first admitted to the home they were very incontinent. They have been able to improve the resident's level of incontinence with a number of different interventions. The PSW said that even with these interventions, the resident would need a minimum of two products per shift. When asked where the number of three to four in 24 hours that was documented on the continence assessment would have come from, the PSW was not sure.

Review of a resident's most recent MDS assessment identified that the resident was incontinent of bladder with multiple daily episodes. The continence assessment stated that the resident had urge and overflow incontinence and used two to three products over 24 hours. The Resident Information Sheet had documented that the resident had one continence product in the allowance bin on each eight hour shift. During an interview with two PSW's they told inspector #568 that the resident would often go to the washroom on their own and then call staff as they had been incontinent. They had tried to put the resident on a scheduled toileting program but the resident was often not compliant. Despite their attempts to toilet the resident as often as possible, they still found that the resident used a minimum of two products but most often three on each shift, or nine over 24 hours.

Interview with PSW and continence team member they told the inspector that they met with the Director of Care (DOC) monthly to review resident's related to their continence, those on scheduled or prompted toileting plans as well as product use. The DOC with the registered staff determined the type of product used by each resident. When asked how the number of products for each resident was determined for the allowance bins, the staff member shared that everyone had one product change in the bin per shift and they were not aware of an assessment that was used to determine this number. The PSW expressed concern that staff spent a great deal of time accessing continence products and this valuable time could be spent on resident care. In addition, it was not fair to have residents waiting, sometimes in uncomfortable conditions, for staff to access a product.

During the inspection two PSW's shared that they were late getting residents to the dining room that morning because they had ten complete bed changes / strips because residents and their bed clothes were saturated with urine. When asked what they thought may be the reason, the staff said it could be because the night staff did not have

sufficient product or time to change the residents.

During an interview with an identified resident they told this inspector that they had lived in the home for some time. Because of their diagnoses they needed help with most of their care. The resident stated that they wore a continence product for occasional bladder incontinence and intermittent bowel incontinence if they did not ring for staff assistance in time. When asked if they ever had to wait to be changed, the resident said that sometimes they don't have the right product. The resident shared that sometimes the staff don't have enough product on their cart so they have to go to ask the nurse to get more. All of this can take some time, between five to ten minutes, but the PSWs do their best not to have you wait too long.

An identified resident told inspector #568 that they had lived in the home for a short time. The resident said that they would call for staff to assist them with toileting. The resident also shared that sometimes they had accidents. When asked if they ever had to wait for staff to change their continence product, the resident said that sometimes they ran out and the staff would say they would be back with another one but it took a little while.

During a telephone interview with the Director of Care they told inspector #568 that they had been working with their continence product provider, and the Registered Nurses Association of Ontario (RNAO) on their continence program. When asked how the home determined the number of continence products to be allocated to their continence bins for each resident on each shift the DOC said that when they started at the home they were told by head office that each resident should be given one product per shift in their allowance bin and if they needed more they could access it from the "buffer bin" or registered staff. The DOC acknowledged that the continence product allowance was not based on an individualized assessment of the resident and that one product per resident was not always sufficient. When asked if the DOC felt that staff having to go to a "buffer bin" or to the registered staff for extra continence product was the most efficient and accessible process, they said that it may not be the best. The DOC agreed that having product more accessible would reduce the wait for residents and allow staff to provide care in a timelier manner. When the DOC was asked if they were aware of the frequency of bed changes on each shift related to incontinence and whether this information was being tracked to determine if the residents' had frequent enough continence product changes or if residents were in the correct product, the DOC said they were not currently doing this.

The licensee failed to ensure that there was a range of continence care products

available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

The severity was determined to be a level two with the potential for actual harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. [s. 51. (2) (f)]

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours,

During a review of an identified resident's clinical record it stated that the resident had a specific diagnoses. The most recent Minimum Data Set (MDS) Assessment identified that the resident's cognitive performance scale (CPS) was three out of six, indicating moderate cognitive impairment. The Resident Assessment Protocol (RAP) for Cognitive Patterns identified that the resident's decision making was moderately impaired and decisions were poor. Supervision and cues were needed.

The Resident's plan of care stated that the resident demonstrated responsive behaviours of a specific nature. There were no interventions documented in the plan of care to mitigate the risk of these behaviours. The plan of care also identified that the resident was at risk for falls characterized by a history of falls and risk factors.

Review of progress notes for the resident identified a number of incidents where the resident exhibited the specified responsive behaviour where there was potential or actual harm to the resident.

During an interview with a Personal Support Worker (PSW) they said that the identified resident was at risk to fall. The PSW said they had never been working when the resident exhibited the specified responsive behaviour but they were aware that they had done this on a couple of occasions. When asked what measures were in place to mitigate the risk of the resident exhibiting these behaviours, the PSW said they would occasionally check on the resident but otherwise they were not aware of anything specific.

The Activities Director told inspector #568 that there had been occasions when the resident demonstrated the specified responsive behaviour. In some situations staff had been concerned about the safety of the resident. When asked if there were interventions in place to mitigate the risk of the resident exhibiting these behaviours, the Activities Director said that staff would occasional check on the resident but they did not have anything formal in place.

During an interview with the Administrator they shared that they were aware that the resident had exhibited the specified behaviours on a few occasions without staff in the home being aware. The Administrator acknowledged that the resident's decision making was moderately impaired and there was potential for harm to the resident as a result of these incidents. The Administrator agreed that the home did not have interventions in place to mitigate the risk of the identified resident's specified behaviour to ensure the resident's safety. [s. 53. (4) (b)]

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours.

Review of a resident's plan of care identified that the resident exhibited behavioural symptoms characterized by specific actions. The resident was a risk for a specified behaviour due to cognitive impairment related to a specific diagnoses. Interventions in

place to address the resident's specified responsive behaviour were outlined in the plan of care.

Review of the resident's progress notes identified at least eleven incidents of the responsive behaviour which posed a potential risk to the resident's safety. While the inspector was in the home there was an incident where the resident exhibited the responsive behaviour. Staff became aware after it occurred and were able to intervene to prevent harm to the resident.

During an interview with a PSW they told the inspector that the identified resident exhibited the specified behaviour on a number of occasions. During several of these incidents staff were concerned about the resident's safety. When asked what measures were in place to prevent the specified behaviour, they said that the resident was on hourly checks but this had just been increased to fifteen minute checks because of the increased incidents of the specified behaviour. The PSW was not aware of any other interventions that were in place.

The BSO staff said they were following the identified resident with respect to the specified responsive behaviour. The BSO staff stated that had tried one specific strategy to address the behaviour but it had not been effective. Up until this last incident, they did not have interventions in place to mitigate the risk of the specified behaviour.

During an interview with the home's Administrator they told inspector #568 that the resident's specified responsive behaviours had increased over the last month. The Administrator acknowledged that the home had not developed and implemented strategies to mitigate the risk of the resident's behaviours and potential risk to their safety.

The licensee failed to ensure that strategies had been developed and implemented for the identified residents related to their specified responsive behaviour.

The severity was determined to be a level two with the potential for actual harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that the licensee informed the Director no later than one business day after the occurrence of the incident of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

Record review identified that a resident was admitted to the home with a specific diagnoses. The plan of care stated that the resident was at risk for a specified responsive behaviour. Interventions to mitigate the risk of this behaviour were outlined in the plan of care.

Progress notes documented five incidents where the identified resident went missing from the home for a period of time.

The Administrator told inspector #568 that they were not aware that they had to inform the Director by submitting a Critical Incident report when a resident went missing from the home. The Administrator acknowledged that the identified resident had gone missing from the home on several occasions during the last year and they had not reported this to the Director.

The severity was determined to be a level one with minimal harm; and the scope of this issue was identified as being a pattern. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee informed the Director no later than one business day after the occurrence of the incident of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An anonymous complaint was filed with the Ministry of Health pertaining to a concern that was brought forward to the home. They said that they had brought their concern forward to the home but never heard anything more about it and felt as though nothing had been done.

The home's policy titled "complaints Process" effective July 2016 and reviewed July 2016, stated that all verbal or written complaints concerning the care of a resident or the operation of the home would be documented, investigated, and formally responded to. If the complaint was about actual or potential harm to a resident the home would investigate immediately. The Complaint Form would be completed by the Administrator/delegate and submitted to the Corporate Office. The Administrator /

delegate should ensure that a documented record of complaints was kept in the home that included (this does not apply to verbal complaints that were resolved within 24 hours), the nature of the complaint, date it was received, type of action taken to resolve the complaint, final resolution, every date on which any response was provided to the complainant, a description of the responses, and any response made in turn by the complainant.

During an interview with the Administrator they told inspector #568 that prior to January 2017, they did not have a formalized process for documenting complaints / concerns and following up with the complainants. Many verbal complaints were investigated and managed but never documented. The Administrator was asked if they had any documentation of a concern brought forward regarding the identified resident. The Administrator was unable to locate a complaint / concern form related to this incident and could not recall anyone having brought this concern forward to them.

During a review of the progress notes for the identified resident there was an entry which stated that the Director of Care had addressed the concern. There was no documentation as to when this concern was brought forward and no documentation to suggest that a response or follow-up was provided to the individual that raised the concern.

The Administrator told inspector #568 that the Director of Care must have handled this situation as per the progress notes. The Administrator acknowledged that they had not followed their current complaints / concerns process and there was no documentation as to when the complaint was received and whether a response had been provided.

The severity was determined to be a level one with minimal harm; and the scope of this issue was isolated. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. [s. 101. (2)]

Issued on this 1st day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2017_600568_0015
Log No. / No de registre :	029839-16, 032453-16, 033515-16, 005151-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 26, 2017
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 LISTOWEL NURSING HOME 710 RESERVE AVENUE SOUTH, LISTOWEL, ON, N4W-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LENORA BELLE

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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act.

O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall ensure that residents are not charged for continence management supplies that the licensee was required to provide to the resident using funding that the licensee received from the LHIN or accommodation charges received under the LTCHA.

The licensee shall ensure:
a) That resident #005, resident #006 and any other resident requiring continence care products are assessed and provided continence care products based on their individual assessed needs as outlined in the regulations, including the specified style of product;
b) Residents and families are made aware of the range of continence products available to them at no cost. Staff in the home communicate with resident #005, resident #006 and any other resident currently providing their own continence product to ensure they are aware there are a range of continence products available to them at no cost.
c) An audit is conducted of all residents that have lived in the home in the year of 2017 to determine if if they had used or are using a specific style continence product:
(i) When the specific style product was/is used the home will determine, when the product was provided by the home, if the resident/representative was providing the product, and if the product was/is an assessed need.
(ii) When the product was provided by the resident/representative the licensee will reimburse all actual or estimated expenses incurred by the resident/representative in 2017, for the full cost of the products used.

Grounds / Motifs :

1. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to a resident using funding that the licensee received from the local health integration network. The Ministry of Health and Long-Term Care (MOHLTC) Funding Policy "LTCH Required Goods, Equipment, Supplies and Services", Date: July 1, 2010 (Funding Policy), part of the L-SAA agreement, provide that the Licensee cannot charge residents for continence management supplies.

The funding policy which is part of the L-SAA agreement, provides that:
The licensee must provide the following goods, equipment and services to long-term care home residents at no charge using the funding the licensee receives from the LHIN or accommodation charges received under the LTCHA.

The funding policy states, under 2.1.2 Continence Management Supplies: Continence management supplies including, but not limited to:
a) A range of continence care products in accordance with section 51 of the Regulation under the LTCHA.

Review of the Resident Information Sheets identified that six residents wore a specified continence product for incontinence.

a) Review of a resident's most recent MDS assessment identified that the resident was frequently incontinent of both bowel and bladder. The most recent continence assessment stated that the resident had occasional urge and overflow incontinence and used their own continence product.

During an interview with the identified resident they told the inspector that they needed assistance to use the washroom. When asked if the home had offered to provide them with the continence products, the resident said they wanted them to wear a different type of product but they found it very uncomfortable and difficult to manage. They preferred to use a specific continence product, and therefore family provided it.

The resident's substitute decision makers (SDMs) shared with this inspector that the home advised them that they did not provide the specified continence product for residents. If they wanted the resident to wear them, they were told they would have to purchase the product and keep a stock in the resident's room. The SDM said they were not told the reason that the home would not provide the specified product, but they assumed it was related to the budget.

b) Review of a resident's most recent MDS assessment identified that the resident was usually continent of bladder and occasionally incontinent of bowel. The continence assessment documented that the resident had urge incontinence. The resident used their own continence products and was aware of the urge to void.

During an interview with a PSW they shared that the identified resident was usually continent of both bowel and bladder with occasional accidents and wore a specific continence product. When asked why the resident provided their own continence products the staff member said the home did not provide this type of product.

When speaking with the identified resident they told the inspector that they had become increasingly independent since they came to the home. The resident said that their family picked up their continence products and brought them in to the home. When asked if the home had offered to provide the products, the resident said "no". The resident said that they preferred this type of product because it was easier for them to manage.

During the course of the inspection three staff told the inspector that the home provided a range of continence products including different liners / pads and briefs in a variety of sizes. They all said that the home did not provide these specific continence products and if residents wished to have them used, their families would need to buy them and bring them in.

During a telephone interview with the Director of Care they shared that the home did not provide any other continence products other than what was shared by staff because of safety concerns. The DOC said that they advised families up front that they didn't provide these specific continence products. At the same time they educated them about the safety concern surrounding the use of the product. If they still wished to have them used then families were told they would need to purchase the specific product and bring them into the home. The DOC said that she was aware of several families that had been providing these specific continence products for their loved ones for some time.

The licensee failed to ensure that residents were not charged for continence products that a licensee was required to provide to a resident using funding received from the LHIN.

The severity was determined to be a level one with minimal harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

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. 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that there is a range of continence care products available to meet the residents' assessed care needs and preference. These products must be accessible to residents and staff at all times, and in sufficient quantities to ensure that residents are provided with the continence product they have been assessed for, and to ensure they are kept clean and dry.

Grounds / Motifs :

1. The licensee failed to ensure there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During interviews with two Personal Support Workers (PSWs) they shared that each wing of the home had a continence product allowance bin for a particular shift. The bins were stocked by the night staff and they could pick them up when they first started their shift. The staff said that the bins contained one product change for each resident that was assessed as needing a continence product. Each cart had a Resident Information Sheet which identified the type of product each resident was to be given for each shift. Staff reported that if they required additional continence products the home's process was for the PSWs to first check the "buffer bin" kept behind the nursing desk. If the product was not available there then they must get a registered staff who had a key to the supply cupboard where more product was stored.

Two other PSW's told inspector #568 that they often ran out of continence products in their allowance bin during a shift. Essentially each resident had only one change, so if they were incontinent of bowel or bladder early in their shift then they would have no further changes available unless they used another resident's product. The PSW's said that sometimes residents were being left in a product because they didn't have another one easily accessible to change them. Many of the residents required more than one product change per shift in order to remain clean and dry. The staff said that it took time to locate extra product, whether it be in the buffer bin or by finding a registered staff to unlock the storage cupboard. Depending if the registered staff was in the middle of a treatment or giving medication they may have to wait ten minutes to even get the product. During this time the residents' would be left to wait in a soiled or wet product and staff were not able to respond to other resident concerns.

PSW's said that sometimes they used a different product than what was identified for the resident in order to save the time of going to find the nurse, or

in situations where the identified product was not available in the home. The staff said that often they ran out of a particular product so they would have to improvise with either a different product or size. Several staff said that they wished the Ministry of Health was in the home every day because when they visited, the amount of continence product in their allowance bins increased.

During interviews with two registered staff they told inspector #568 that if the PSWs ran out of continence product in their allowance bins, they would first check the "buffer bin" located at the nursing desk. If the product was not available there then they would come to one of the registered staff who had a key to the room where extra product was kept. When asked if they always had the correct product available, both staff said that sometimes they ran out of a particular product and would have to substitute with another product or size. This would occur most often towards the end of the week. When asked how often staff came to them during a shift to ask for an extra product, they both said usually a couple of times but sometimes more or less often depending on the day. The registered staff said usually they were able to respond quickly to the staff request, but there were occasions where they had to wait if they were in the middle of a treatment or if they didn't have the keys.

Record review identified that the "Resident Information Sheets to Reflect Care Plan" for South Hall and East Wing identified that in total there were 36 incontinent residents. The worksheet for each wing of the home identified the resident, room number, and the type and number of continence product to be used for the resident on each shift. Of the 36 incontinent residents, only one resident was given an extra product change on one shift. The remaining residents were provided one product change in the allowance bin for an eight our time period.

Review of a resident's admission Minimum Data Set (MDS) assessment identified that the resident was frequently incontinent of urine and occasionally incontinent of bowel. The continence assessment stated that the resident had urge and overflow incontinence and would need three to four incontinence products each day. The Resident Information Sheet had documented that the identified resident had one continence product in the allowance bin for each eight hour shift. During an interview with a Personal Support Worker and continence team member they said that when the resident was first admitted to the home they were very incontinent. They have been able to improve the resident's level of incontinence with a number of different interventions. The

PSW said that even with these interventions, the resident would need a minimum of two products per shift. When asked where the number of three to four in 24 hours that was documented on the continence assessment would have come from, the PSW was not sure.

Review of a resident's most recent MDS assessment identified that the resident was incontinent of bladder with multiple daily episodes. The continence assessment stated that the resident had urge and overflow incontinence and used two to three products over 24 hours. The Resident Information Sheet had documented that the resident had one continence product in the allowance bin on each eight hour shift. During an interview with two PSW's they told inspector #568 that the resident would often go to the washroom on their own and then call staff as they had been incontinent. They had tried to put the resident on a scheduled toileting program but the resident was often not compliant. Despite their attempts to toilet the resident as often as possible, they still found that the resident used a minimum of two products but most often three on each shift, or nine over 24 hours.

Interview with PSW and continence team member they told the inspector that they met with the Director of Care (DOC) monthly to review resident's related to their continence, those on scheduled or prompted toileting plans as well as product use. The DOC with the registered staff determined the type of product used by each resident. When asked how the number of products for each resident was determined for the allowance bins, the staff member shared that everyone had one product change in the bin per shift and they were not aware of an assessment that was used to determine this number. The PSW expressed concern that staff spent a great deal of time accessing continence products and this valuable time could be spent on resident care. In addition, it was not fair to have residents waiting, sometimes in uncomfortable conditions, for staff to access a product.

During the inspection two PSW's shared that they were late getting residents to the dining room that morning because they had ten complete bed changes / strips because residents and their bed clothes were saturated with urine. When asked what they thought may be the reason, the staff said it could be because the night staff did not have sufficient product or time to change the residents.

During an interview with an identified resident they told this inspector that they had lived in the home for some time. Because of their diagnoses they needed

help with most of their care. The resident stated that they wore a continence product for occasional bladder incontinence and intermittent bowel incontinence if they did not ring for staff assistance in time. When asked if they ever had to wait to be changed, the resident said that sometimes they don't have the right product. The resident shared that sometimes the staff don't have enough product on their cart so they have to go to ask the nurse to get more. All of this can take some time, between five to ten minutes, but the PSWs do their best not to have you wait too long.

An identified resident told inspector #568 that they had lived in the home for a short time. The resident said that they would call for staff to assist them with toileting. The resident also shared that sometimes they had accidents. When asked if they ever had to wait for staff to change their continence product, the resident said that sometimes they ran out and the staff would say they would be back with another one but it took a little while.

During a telephone interview with the Director of Care they told inspector #568 that they had been working with their continence product provider, and the Registered Nurses Association of Ontario (RNAO) on their continence program. When asked how the home determined the number of continence products to be allocated to their continence bins for each resident on each shift the DOC said that when they started at the home they were told by head office that each resident should be given one product per shift in their allowance bin and if they needed more they could access it from the "buffer bin" or registered staff. The DOC acknowledged that the continence product allowance was not based on an individualized assessment of the resident and that one product per resident was not always sufficient. When asked if the DOC felt that staff having to go to a "buffer bin" or to the registered staff for extra continence product was the most efficient and accessible process, they said that it may not be the best. The DOC agreed that having product more accessible would reduce the wait for residents and allow staff to provide care in a timelier manner. When the DOC was asked if they were aware of the frequency of bed changes on each shift related to incontinence and whether this information was being tracked to determine if the residents' had frequent enough continence product changes or if residents were in the correct product, the DOC said they were not currently doing this.

The licensee failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

The severity was determined to be a level two with the potential for actual harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 24, 2017

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that for resident #013, resident #007 and any other resident residing in the home that exhibits behavioural symptoms characterized by wandering and risk of elopement, that:
a) behavioural triggers are identified
b) strategies to mitigate the risk of these behaviours are developed and implemented
c) the effectiveness of these strategies are evaluated and when they are not effective new strategies are implemented in order to ensure the safety of the residents.

Grounds / Motifs :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours,

Review of a resident's plan of care identified that the resident exhibited behavioural symptoms characterized by specific actions. The resident was a risk for a specified behaviour due to cognitive impairment related to a specific diagnoses. Interventions in place to address the resident's specified responsive behaviour were outlined in the plan of care.

Review of the resident's progress notes identified at least eleven incidents of the responsive behaviour which posed a potential risk to the resident's safety. While

the inspector was in the home there was an incident where the resident exhibited the responsive behaviour. Staff became aware after it occurred and were able to intervene to prevent harm to the resident.

During an interview with a PSW they told the inspector that the identified resident exhibited the specified behaviour on a number of occasions. During several of these incidents staff were concerned about the resident's safety. When asked what measures were in place to prevent the specified behaviour, they said that the resident was on hourly checks but this had just been increased to fifteen minute checks because of the increased incidents of the specified behaviour. The PSW was not aware of any other interventions that were in place.

The BSO staff said they were following the identified resident with respect to the specified responsive behaviour. The BSO staff stated that had tried one specific strategy to address the behaviour but it had not been effective. Up until this last incident, they did not have interventions in place to mitigate the risk of the specified behaviour.

During an interview with the home's Administrator they told inspector #568 that the resident's specified responsive behaviours had increased over the last month. The Administrator acknowledged that the home had not developed and implemented strategies to mitigate the risk of the resident's behaviours and potential risk to their safety. (568)

2. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours,

During a review of an identified resident's clinical record it stated that the resident had a specific diagnoses. The most recent Minimum Data Set (MDS) Assessment identified that the resident's cognitive performance scale (CPS) was three out of six, indicating moderate cognitive impairment. The Resident Assessment Protocol (RAP) for Cognitive Patterns identified that the resident's decision making was moderately impaired and decisions were poor. Supervision and cues were needed.

The Resident's plan of care stated that the resident demonstrated responsive behaviours of a specific nature. There were no interventions documented in the plan of care to mitigate the risk of these behaviours. The plan of care also

identified that the resident was at risk for falls characterized by a history of falls and risk factors.

Review of progress notes for the resident identified a number of incidents where the resident exhibited the specified responsive behaviour where there was potential or actual harm to the resident.

During an interview with a Personal Support Worker (PSW) they said that the identified resident was at risk to fall. The PSW said they had never been working when the resident exhibited the specified responsive behaviour but they were aware that they had done this on a couple of occasions. When asked what measures were in place to mitigate the risk of the resident exhibiting these behaviours, the PSW said they would occasionally check on the resident but otherwise they were not aware of anything specific.

The Activities Director told inspector #568 that there had been occasions when the resident demonstrated the specified responsive behaviour. In some situations staff had been concerned about the safety of the resident. When asked if there were interventions in place to mitigate the risk of the resident exhibiting these behaviours, the Activities Director said that staff would occasional check on the resident but they did not have anything formal in place.

During an interview with the Administrator they shared that they were aware that the resident had exhibited the specified behaviours on a few occasions without staff in the home being aware. The Administrator acknowledged that the resident's decision making was moderately impaired and there was potential for harm to the resident as a result of these incidents. The Administrator agreed that the home did not have interventions in place to mitigate the risk of the identified resident's specified behaviour to ensure the resident's safety.

The licensee failed to ensure that strategies had been developed and implemented for the identified residents related to their specified responsive behaviour.

The severity was determined to be a level two with the potential for actual harm; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years. (568)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 24, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 26th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

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