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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2017	2017_263524_0005	002419-17	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 ON BONNIE PLACE
15 Bonnie Place St Thomas ON N5R 5T8

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

INA REYNOLDS (524), ADAM CANN (634), JANETM EVANS (659), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 30, 31, February 1, 2, 3, 6, 7, 8, 9, 2017.

The following intakes were completed within the RQI:
Log # 008957-16 Follow-up related to bed rails, bed entrapment and continence program
Log # 018710-16 / CIS 2730-000008-16 Critical Incident related to elopement
Log # 014085-16 / IL-44574-LO Complaint related to personal care, missing items and laundry service
Log # 009295-16 / IL-43882-LO Complaint related to allegation of resident abuse.

During the course of the inspection, the inspector(s) spoke with two Acting Administrators, a Regional Consultant, the Director of Nursing, the Resident Care Coordinator, the Resident Assessment Instrument Coordinator, the Food Service Manager, the Maintenance Supervisor, the Activity Coordinator, the Retirement Home Manager, two Registered Nurses, four Registered Practical Nurses, one Physiotherapist Assistant, seventeen Personal Support Workers, one Ward Clerk, one Administrative Assistant, one Dietary Aide, one Laundry Aide, the Residents' Council Representative, 40 residents and three family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, dining service, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, internal investigation notes, relevant policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_260521_0004	524
O.Reg 79/10 s. 48. (1)	CO #002	2016_260521_0004	524

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Observation was completed of an identified resident who received their presribed medication from a Registered Practical Nurse (RPN) on a specific date and time.

Interview was completed with an RPN on an identified date and time. The RPN said that they had administered the resident's medication at an identified time and date. The RPN said that the medication was a specific type of medication and should be administered in accordance with how it was prescribed for. The RPN said that there was no process in place for identifying which medications were to be administered at identified times.

Another Registered Practical Nurse (RPN) said that they were consistently completing their morning medication pass between 1030 hours and 1100 hours. The RPN said that identified specific medications were not being administered as ordered on a consistent basis. The RPN stated that the home went from three medication carts to two medications carts in the fall of 2016. The RPN said that each medication cart was stocked for a registered staff to administer medications to multiple residents and they were unable to complete the medication pass in a timely manner.

Interview was conducted with a third RPN on a specific date and time. The RPN said that they had just completed their 0800 hour medication pass at 1040 hours and that they consistently completed their morning medication pass around 1100 hours each day. The RPN said that there was not a process in place to identify which medications were to be administered at identified times. The RPN said that the home went from three medication carts to two in the fall of 2016, and since then timely medication administration has been a challenge.

Interview was completed with a fourth RPN on a specific date and time. The RPN said that they had been having difficulty with administering medications in a timely manner since August 2016. The RPN said that they were finished their morning 0800 hour medication pass at 1030 hours and said that identified medications were not administered as prescribed.

Record review of the home's "The Medication Pass" policy 3-6 dated January 2014, stated "All medications administered are listed on the resident's MAR. Each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route".

Record review of the Guidelines for timely medication administration from the Institute for Safe Medication Practices stated for time specific medications "the time indicated when necessary or within 30 minutes before or 30 minutes after the scheduled time. For daily, weekly, or monthly medications, administer these medications plus or minus 2 hours from the scheduled time. For medications administered more frequently than daily but not more frequently than every 4 hours, administer these medications plus or minus one hour from the scheduled time. Medications administered more frequently than every 4 hours, administer these medications within 25 % of the dosing interval (e.g. plus or minus 15 minutes for hourly doses, plus or minus 30 minutes for every 2 hours dosing, plus or minus 45 minutes for every 3 hour dosing)." The DON said that these were the guidelines and expectations that the home utilized for medication administration.

Interview with the Director of Nursing (DON) who said that they were aware that medications were being administered outside the guidelines for medication administration. The DON said that the medication administered to an identified resident was not administered on an identified date to the resident in accordance with the directions for use specified by the prescriber. The DON said that it was the home's expectation that medications were to be administered to residents in accordance with the directions for use specified by the prescriber.

The scope of this area of non-compliance was widespread and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 21, 2016. [s. 131. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that sets out clear direction to staff and others who provided direct care to the resident.

An observation was completed of an identified resident on two specific dates. The resident was observed wearing a personal assistive services device (PASD). Observation on a specific date, of the resident's room noted a logo chart posted on the resident's closet. There was no evidence of a PASD checked off on the logo board for the resident.

A record review was completed of the most recent plan of care on February 8, 2017.

There was no documented evidence of a PASD in the plan of care for the resident. Record review of the policy and procedure for Personal Assistive Service Devices dated July 2016 stated, "All residents who use PASD's shall have this documented on the Resident Plan of Care."

Staff interview with two Personal Support Workers on a specific date, both said that they were not aware that the resident was using a PASD. Upon interview with Registered Practical Nurse (RPN) on a specific date, it was acknowledged that the resident was using a PASD and that the PASD was requested by family. The RPN agreed that the PASD should have been documented in the resident plan of care.

The Director of Nursing on an identified date, agreed that the home's expectation was that all residents who use PASD's would have this documented on the resident's plan of care. [s. 6. (1)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) An identified resident was assessed for continence care management. The plan of care documented that registered staff were to assess each time the resident requested to use a certain type of personal assistive services device (PASD) as to whether it was safe for staff to use an identified transfer device.

On two identified dates, staff were observed to assist the resident with use of the PASD. Two PSW's stated that the resident was not assessed for use of the transfer device prior to use of the PASD. Director of Nursing stated that staff should be following what the resident's preference was and that the plan of care should be followed to ensure resident safety.

B) A record review was completed of a resident's plan of care in Point Click Care. The plan of care documented that the resident used a PASD while seated and the resident was able to remove the PASD on their own.

Observation was conducted on an identified date and time of the logo system in the resident's room. The logo noted that the resident was to have a PASD applied when seated. Observation was then conducted of the resident at a later time and the resident did not have their PASD applied while seated.

Interview was conducted with a Personal Support Worker (PSW) on a specific date and time. The PSW referred to the resident's cabinet where the logo system was displayed. The PSW verified that the logo noted that the resident was to have a PASD on while seated. The PSW acknowledged that the PASD was not applied as specified in the plan of care.

C) Record review of the most recent plan of care and kardex for an identified resident under the risk for falls focus stated that the resident was at risk for falls. The plan of care directed staff to have the "call bell within easy reach at all times" and to reinforce the need to "call for assistance".

On an identified date and time, the resident was observed to be lying in bed, the call bell was not accessible to the resident and was found to be behind the head of the bed on the floor.

Upon interview with a Personal Support Worker it was stated that the resident would be able to use a call bell. The Director of Nursing acknowledged that the resident's call bell should have been within the resident's reach when in their room. [s. 6. (7)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Review of the plan of care for an identified resident stated to "follow facility protocol / regime for treating skin integrity" and to see the "treatment sheet for specific treatment protocol." Further review of the clinical record showed that the resident's altered skin integrity was healed.

During staff interview with the Resident Care Coordinator (RCC), a Personal Support Worker (PSW) and Registered Nurse (RN) on a specific date and time, it was acknowledged that the resident's altered skin integrity was healed. The RCC and RN shared that it was the responsibility of registered staff to review and revise the plan of care when the care set out in the plan was no longer necessary.

During staff interviews with the Resident Care Coordinator and Director of Nursing on a specific date and time, it was agreed that the home's expectation was that care plans were reviewed and revised when the care set out in the plan was no longer necessary.

The scope of this area of non-compliance was isolated and the severity was determined

to be minimal harm/risk or potential for actual harm/risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on February 5, 2016, January 21, 2016, August 20, 2015, January 16, 2015 and September 2, 2014. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care that sets out clear direction to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, and that the residents plan of care is reviewed and revised when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated.

Review of the clinical record for an identified date showed a progress note documented by Director of Nursing (DON) which noted a resident alleged a Personal Support Worker (PSW) had taken an identified amount of money from them. The licensee was unable to provide evidence of an investigation into the alleged incident at the time of its reporting.

In an interview DON stated the alleged incident had been investigated on an identified date. Documentation from the DON to the resident's power of attorney acknowledged the allegation but had not provided evidence that an immediate investigation had been completed.

The scope of this area of non-compliance is isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who had received training under section (2) received retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations.

Record review of the "Caressant Care on Bonnie Place In-Service training record – Mandatory" for 2016 showed that approximately 15-24% of staff members across all disciplines had not signed off the mandatory annual training as completed as follows:
- Zero Tolerance of Abuse and Neglect
- Duty to make mandatory reports under section 24
- Residents' Bill of Rights
- Whistle Blowing protections
- Emergency Response/Evacuation training
- Emergency Training - all codes
- Cleaning / Sanitizing Equipment (all departments).

Director of Nursing acknowledged that the training had not been completed.

Upon interview with the Acting Administrator on February 9, 2017, it was stated that the home had a Calendar of Education posted in the home and it was the expectation that all staff complete the mandatory retraining sessions as required.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 20, 2015. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the persons who have received training under section (2) receive retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including resident bedrooms and common areas.

Observations of common areas and resident bedrooms and bathrooms on January 30, 31 and February 1, 2017, showed one or more of the following:
- multiple bathroom floors and baseboards were dirty, soiled or stained, dirt was in the corners
- a bathroom vent was covered in a thick layer of dust with cobwebs
- corrosion was on and around the base of a toilet
- layer of dust and debris was under numerous resident beds
- perimeter of multiple rooms were dusty and unclean
- multiple rooms with cobwebs in corners
- baseboards were soiled
- a television was covered in a layer of dust
- dust balls/debris/soiled area under baseboard heater and under a resident's bed
- ceiling vent in a lounge area was covered in a thick layer of dust and cobwebs; window sill corners were covered with cobwebs; perimeter of the room was soiled with debris and a build-up of dust and cobwebs in the corners.

Review of the Family Council meeting minutes dated November 8, 2016, documented that a family member was concerned about the cleanliness of the lounges and their family member's room. The window ledges were dirty and the bathroom in their room was "smelly and dirty" and there was dust under the bed. They also felt that the extension toilets were not being cleaned properly. The response from the Administrator dated November 14, 2016, noted that the "cleaning routines are currently being reviewed

to ensure all areas are being properly cleaned and maintained". Review of the Family Council meeting minutes dated January 31, 2017, also noted a concern that the cleaning under bed frames was not happening on a regular basis.

Review of the Resident Council meeting minutes dated October 17 and December 19, 2016, expressed a concern that the dusting of dressers and shelves in resident rooms were not being done. The response from the Administrator dated October 25, 2016, noted that the "cleaning routines were being reviewed to ensure all areas were being properly cleaned and maintained", and on December 19, 2016, that the housekeepers "do not move furniture or knick knacks when they are cleaning and must only clean around them".

Review of the home's "Thorough Clean" schedule stated to housekeeping staff that "thorough clean includes all daily cleaning items, stripping and re-waxing floors, pulling out all furniture, cleaning inside windows and window sills, washing the walls and ceilings, dusting high and low, and changing the curtains as necessary".

Upon interview with the Acting Administrator on February 6, 2017, it was stated that two housekeeping staff for 8 hours, 7 days per week were responsible for daily cleaning routines plus on Tuesday, Thursday, Saturday and Sunday were responsible for thorough deep cleaning semi-private and private rooms; in addition, two housekeeping staff for 6.5 hours every other week were responsible for thorough deep cleaning of all other resident rooms and lounges as per schedule. Housekeeping staff were expected to clean resident rooms on a daily basis including dusting and dry and wet mopping of floors. Thorough deep cleaning would have included moving furniture, stripping and waxing floors if required, cleaning the perimeter of the room, and steam cleaning walls and floors if required. The Acting Administrator acknowledged that despite cleaning routines and audits in place, not all housekeeping staff had implemented the home's policy and completed their tasks of thoroughly cleaning resident bedrooms and common areas.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimum risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 25, 2016 and January 16, 2015. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for cleaning of the home, including resident bedrooms and common areas, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating,
i. what the licensee had done to resolve the complaint, or
ii. that the licensee believed the complaint was unfounded and the reasons for the belief.

Review of the licensee's investigation file included documentation from an identified resident's family member to the Administrator at Bonnie Place. This documentation noted that a few months ago they had communicated with the home regarding the loss of an identified resident's personal care item and that they had not received a reply. In addition to this, there was documentation from resident's power of attorney (POA) which included that the family had filed a complaint a few months ago regarding the loss of the resident's personal care item but the home had not replied. Documentation from the licensee's investigation file showed that Director of Nursing (DON) had responded to the POA for the complaint, but there was no documentation that a response had been made to resident's family member.

In an interview with the DON it was acknowledged that they had not responded to the resident's family member to indicate what had been done to resolve the complaint or whether the licensee believed the complaint was unfounded and the reasons for the belief. Acting Administrator acknowledged that they should have responded to the complainant and that the home did not comply with the legislation. [s. 101. (1) 3.]

2. The licensee has 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.

Review of the clinical record progress note documentation by the Director of Nursing (DON) on an identified date stated the DON approached an identified resident to speak with them about a "concern regarding care". Review of complaints log had not shown any log of a concern for this resident on or around the date of the progress note and review of the investigation file provided had not shown evidence of any additional information related to the concern that was expressed.

Two complaints on an identified date were received, one from resident's power of attorney (POA) and one from the resident's family member. The licensee's report of complaint form logged the nature of the complaint as a missing personal item however

the complaint had included that resident's property was not treated with respect; and that several identified devices were destroyed by staff. In addition to this, the complaint stated that a number of other personal items had gone missing. These additional items were not documented on the complaint log. DON had not maintained a document listing all actions taken, when they were taken and by whom nor had they documented the final disposition.

A response to the complainant had been made on an identified date, that included some actions that had been taken by the licensee but no time frame was noted for the actions or follow up. There was also a notation that the DON spoke to the resident about a concern of the care staff; this item did not appear to be documented in the complaint to the home.

A response from the complainant, requested that the licensee cover the cost of the replacement for the identified personal item, that the resident be permitted to have a device so they could access their personal belongings and that when issues arose they be resolved with the family and an order for contacting family was provided.

A licensee response by DON on a specific date, requested clarification as to the type of device the family were requesting; and, acknowledged the complainants request that the home bring concerns forward to the family instead of the resident. The licensee also included in their response to the complainant, that an inquiry was made to staff to notify them about the family concerns; there was no time frame documented as to when the inquiry was completed. There was documentation related to a report being received from a Personal Support Worker (PSW) regarding the resident's personal belongings but there was no documentation as to the time frame of when the report was received from the PSW.

A response on Caressant Care Nursing and Retirement Home's letterhead addressed to the complainant on an identified date, documented that a thorough investigation was conducted and a search was commenced but the resident's personal care item was not located. It noted that as per Schedule F signed on admission to the home, Caressant Care was not responsible for any valuables left with the resident.

Documentation on an identified date, to the complainant noted that the resident was asking a Personal Support Worker for their personal belonging back. The documentation included that the Director of Nursing did not believe that the PSW took the personal belonging.

In interviews completed with DON, the DON acknowledged that they had not maintained records of complaints in accordance with the legislation. The DON stated that the complaint log documentation was sporadic and that the log was a little out of line with the dates as they tried to deal with issues and they did not log everything in as a complaint as they could spend their whole day doing this. [s. 101. (2)]

3. The licensee has failed to ensure that (a) the documented record (of complaints received) was reviewed and analyzed for trends at least quarterly (b) the results of the review and analysis were taken into account in determining what improvements were required in the home, and (c) a written record was kept of each review and of the improvements made in response.

A review of the licensee's documentation related to the 2016 complaint records showed that the licensee had not completed the required third or fourth quarter analysis.

The DON acknowledged during an interview, that the quarterly analysis of complaints had not been completed for 2016.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 16, 2015. [s. 101. (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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response to the person who made the complaint, that a documented record is kept in the home of the complaint, and that the documented record of complaints is reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Record review of the Guidelines for timely medication administration from the Institute for Safe Medication Practices stated for time specific medications "the time indicated when necessary or within 30 minutes before or 30 minutes after the scheduled time. For daily, weekly, or monthly medications, administer these medications plus or minus 2 hours from the scheduled time. For medications administered more frequently than daily but not more frequently than every 4 hours, administer these medications plus or minus one hour from the scheduled time. Medications administered more frequently than every 4 hours, administer these medications within 25 % of the dosing interval (e.g. plus or minus 15 minutes for hourly doses, plus or minus 30 minutes for every 2 hours dosing, plus or minus 45 minutes for every 3 hour dosing)." The DON said that these were the guidelines and expectations that the home utilized for medication administration.

Record review was completed of two residents' Medication Administration Record (MAR) and the corresponding Physician Order Audit Reports. The Physician Order Audit report showed that the residents medications were not administered as ordered on a specific date and time.

Interview was completed with a Registered Practical Nurse (RPN) on a specific date. The RPN said that when medication was administered as ordered, a checkmark with nurse's initials appeared on the MAR. The RPN said that when a medication was administered outside of accepted guidelines for medication administration, they should have noted a number nine on the Medication Administration Record. The RPN said that the number nine showed that the medication was not administered as ordered.

Interview was completed with the Director of Nursing (DON). The DON said that there was not a written procedure or protocol on the expectation for documenting medications which have been provided outside the guidelines for administration. The DON said that the staff should be noting a number nine on the Medication Administration Record for resident's who did not receive medications within the guidelines for administration.

The scope of this area of non-compliance is isolated and the severity was determined to be potential for risk. The home had unrelated non-compliance in the last three years. [s. 114. (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 written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Record review was completed of medication incidents provided by the home for the months of October, November and December 2016. Three medication incidents were identified during the time frame.

Record review was completed of Professional Advisory Committee (PAC) meeting minutes from January 11, 2017. The meeting minutes had not stated that a review was completed of the medication incidents from the previous quarter.

Interview was completed with the Director of Nursing (DON). The DON said that if the medication incidents were reviewed and analyzed during their PAC meeting, they would be included in the meeting minutes for the meeting. The DON said that the medication incidents were not reviewed and they should have been.

The scope of this area of non-compliance is widespread and the severity was determined to be miminum risk. The home had unrelated non-compliance in the last three years. [s. 135. (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 a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to continence care and bowel management to all staff who provided direct care to residents was provided: on either an annual basis, or based on the staff's assessed training needs.

A review of the annual training documentation from 2016 related to continence care and bowel management for direct care staff showed that 17 of 72 (24%) direct care staff had not completed the training. Director of Nursing acknowledged that not all direct care staff had completed the training on continence care and bowel management.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 221. (1) 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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to continence care and bowel management at intervals provided for in the regulations: O. Reg 79/10 s. 221 (2) 1: the staff must receive annual training in all areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #10: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) An identified resident was line listed with identified symptoms and there were postings on their door identifying precautions that should be used when providing care with this resident. Personal protective equipment (PPE) was placed at the entrance to the room. On two identified dates, three personal support workers were observed to enter the residents room without applying the required personal protective equipment. Staff acknowledged they were aware of the signage and that they should have applied the PPE to enter the room and provide care to the resident.

Acting Administrator stated that staff should have been aware of the requirements and knowledgeable related to the infection prevention and control procedure and where appropriate should have worn personal protective equipment.

B) An observation of an identified room was completed on certain date and time. A soiled bed pan with brown residue on the rim and inside the bed ban was observed to be stored in unclean manner on the back of a plastic toilet lid in a shared resident bathroom.

A Personal Support Worker verified the soiled bed pan and immediately removed the bed pan. Upon interview with the Personal Support Worker it was stated that a soiled bed pan should not be stored on the back of a resident toilet and should have been transported to the soiled utility room immediately after use. The Director of Nursing acknowledged that bed pans were not to be stored in resident rooms and should have been taken to the soiled utility room after use to be cleaned as part of the infection control program.

C) Multiple unlabelled personal care items were observed in an identified room of a shared residents' bathroom. This was verified by the Resident Care Coordinator (RCC). The RCC said that personal care items were to be labelled with the resident's name when stored in shared bathrooms and removed the items. The Director of Nursing acknowledged that residents' personal care items in shared bathrooms should be labelled as part of the infection prevention program.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 21, 2016. [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 prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

During stage one observations on January 30, 2017 at 0920 hours, it was noted that there was a door which was unlocked leading to a dining area. Inside the dining area was a hot steam table which was on, as evidenced by the red lights on the steam table and also the top of the steam table was hot to touch. Observation was then conducted on January 31, 2017 at 1500 hours, by two Inspectors and the door leading to the dining area was open and unlocked. The hot steam tables were on as evidenced by the four red lights on the steam table and they were also warm to touch. There were no signs indicating that the steam table could be hot and the steam table did not have any protection surrounding it.

Interview was conducted with a Regional Consultant. The Regional Consultant said that when the steam tables were on, residents were not to be in the room and the door should be locked. It was further said that the door was not locked and it should have been.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident beds are capable of being elevated at the head and have a headboard and a footboard.

Observation of a bed system on an identified date and time, noted a missing footboard on a resident's bed.

Review of progress notes for a specific date, by a registered practical nurse stated that the footboard was removed from the resident's bed related to a behaviour. Further review of a progress noted on an identified date, stated that the behaviour had decreased since an identified intervention was initiated. Review of the current plan of care in Point Click Care showed an absence of information related to the behaviour.

Upon interview with the Maintenance Supervisor it was stated that they were asked to remove the footboard by nursing staff and was not aware that the resident's bed required a footboard.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 12. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required relating to activities of daily living.

Record review of the Minimum Data Set (MDS) quarterly review assessment on a specific date, under the physical function section noted that an identified resident required extensive assistance with one person to provide physical assistance with eating. The resident was identified as being at nutritional risk.

Record review of the most recent plan of care and kardex on Point Click Care for the resident showed there were no interventions with respect to the type and level of eating assistance that was required for the resident.

Upon interview with the Resident Assessment Instrument (RAI) Coordinator it was acknowledged that interventions related to the resident's type and level of assistance required relating to eating was not in the plan or care and that it should be.

The scope of this area of non-compliance is isolated and the severity was determined to be potential for risk. The home had unrelated non-compliance in the last three years. [s. 26. (3) 7.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted prior to hiring a staff member who was 18 years of age or older.

A review of five employee files for criminal reference checks was completed. One of the five employee files showed that the criminal reference check was completed after the employee's first worked shift. When asked what the expectation for criminal record checks for staff was in accordance with the legislation the Acting Administrator stated that staff were to provide a criminal record check prior to working.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 75. (2)]

WN #15: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after the occurrence of a resident who was missing for less than three hours.

Review of a Critical Incident System report and progress notes noted that an identified resident was missing from the home on a specific date. A code yellow was called, a search was initiated and the police were called. Staff provided police with details and description of the resident and shortly after, the police received notification that the resident was in the hospital emergency department. A concerned citizen had seen the resident fall outside on the street and had called an ambulance. The resident returned from the hospital with no injuries.

The Director was notified of the missing occurrence of the resident later than one business day after the occurrence.

Upon interview with the Acting Administrator it was stated that management staff should have reported the incident within the appropriate time frame.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 107. (3) 1.]

Issued on this 29th day of May, 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) :	INA REYNOLDS (524), ADAM CANN (634), JANETM EVANS (659), NANCY JOHNSON (538)
Inspection No. / No de l'inspection :	2017_263524_0005
Log No. / Registre no:	002419-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 28, 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 ON BONNIE PLACE 15 Bonnie Place, St Thomas, ON, N5R-5T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Justyna Zmuda

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that time specific medications are administered to residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Observation was completed of an identified resident who received their presribed medication from a Registered Practical Nurse (RPN) on a specific date and time.

Interview was completed with an RPN on an identified date and time. The RPN said that they had administered the resident's medication at an identified time and date. The RPN said that the medication was a specific type of medication and should be administered in accordance with how it was prescribed for. The RPN said that there was no process in place for identifying which medications were to be administered at identified times.

Another Registered Practical Nurse (RPN) said that they were consistently completing their morning medication pass between 1030 hours and 1100 hours. The RPN said that identified specific medications were not being administered as ordered on a consistent basis. The RPN stated that the home went from three medication carts to two medications carts in the fall of 2016. The RPN said that each medication cart was stocked for a registered staff to administer medications to multiple residents and they were unable to complete the medication pass in a timely manner.

Interview was conducted with a third RPN on a specific date and time. The RPN said that they had just completed their 0800 hour medication pass at 1040 hours and that they consistently completed their morning medication pass around 1100 hours each day. The RPN said that there was not a process in place to identify which medications were to be administered at identified times. The RPN said that the home went from three medication carts to two in the fall of 2016, and since then timely medication administration has been a challenge.

Interview was completed with a fourth RPN on a specific date and time. The RPN said that they had been having difficulty with administering medications in a timely manner since August 2016. The RPN said that they were finished their morning 0800 hour medication pass at 1030 hours and said that identified medications were not administered as prescribed.

Record review of the home's "The Medication Pass" policy 3-6 dated January 2014, stated "All medications administered are listed on the resident's MAR. Each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route".

Record review of the Guidelines for timely medication administration from the Institute for Safe Medication Practices stated for time specific medications "the time indicated when necessary or within 30 minutes before or 30 minutes after the scheduled time. For daily, weekly, or monthly medications, administer these medications plus or minus 2 hours from the scheduled time. For medications administered more frequently than daily but not more frequently than every 4 hours, administer these medications plus or minus one hour from the scheduled time. Medications administered more frequently than every 4 hours, administer these medications within 25 % of the dosing interval (e.g. plus or minus 15 minutes for hourly doses, plus or minus 30 minutes for every 2 hours dosing, plus or minus 45 minutes for every 3 hour dosing)." The DON said that these were the guidelines and expectations that the home utilized for medication administration.

Interview with the Director of Nursing (DON) who said that they were aware that medications were being administered outside the guidelines for medication administration. The DON said that the medication administered to an identified resident was not administered on an identified date to the resident in accordance with the directions for use specified by the prescriber. The DON said that it was the home's expectation that medications were to be administered to residents in

accordance with the directions for use specified by the prescriber.

The scope of this area of non-compliance was widespread and the severity was determined to be potential for risk. The home had a history of non-compliance in this sub-section of the legislation as it was previously issued on January 21, 2016. [s. 131. (2)] (634)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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 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 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 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 28th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ina Reynolds

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