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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 31, 2018;	2018_363659_0003 (A1)	001163-18	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 Mary Bucke
4 Mary Bucke Street ST. THOMAS ON N5R 5J6

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

Amended by JANETM EVANS (659) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension of Compliance due date until July 27, 2018.

Issued on this 31 day of May 2018 (A1)

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

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Amended by JANETM EVANS (659) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 22, 23, 24, 25, 26, 29, 30, 31, 2018 and February 1, 2018.

The following intakes were included with the Resident Quality Inspection (RQI):

Log# 026161-17, Follow up inspection to Compliance Order #001 from Follow-up inspection #2017_536537_0040 related to pain assessments

Log #002092-18\ 2627-000002-18 critical incident related to alleged emotional abuse

Log #002093-18\2627-000001-18 critical incident related to alleged improper care

Log #002140-18\2627-000003-18 critical incident related to alleged physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the interim Director of Nursing, the Resident Assessment Instrument (RAI) Coordinator, the Pharmacist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, Physiotherapy Assistant, Activity Aide, Restorative Care Aide, Dietary Aide, Housekeeping staff, Resident Council representative, residents and family members.

The inspector(s) conducted a tour of the home, and reviewed clinical records

and plans of care for relevant residents, pertinent policies and procedures and Residents' and Family Council minutes. Observations were also made of the provision of care, dining, staff to resident interactions, medication administration and storage areas, infection prevention and control practices, general maintenance, cleanliness and condition of the home and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

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

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Skin and Wound Care

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

7 WN(s)
6 VPC(s)
1 CO(s)
1 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with. O. Reg. 79/10, s. 8 (1).

During the Follow-Up Inspection #2017_536537_0040, Compliance Order (CO) #001 was reissued on November 15, 2017, and ordered the licensee to take action to achieve compliance by ensuring that the home's "Pain Assessment" policy was complied with. This order was to be complied by December 29, 2017.

The home's Pain Assessment policy with review date May 2015 stated the following:
"1. Caressant Care recognizes that RAI MDS as a comprehensive assessment. Residents who score a two (2) or higher on any Minimum Data Set Resident Assessment Instrument (MDS-RAI) assessment under section J2 will have a further pain assessment completed using the Caressant Care Pain Assessment Tool on Point Click Care (see Appendix A). This assessment will also be utilized when: a new medication is initiated, a resident exhibits behaviour that may herald the onset of pain, a resident complains of pain of four or greater, a resident exhibits distress related behaviours or facial grimace, a resident/family/staff/volunteers indicate pain is present.

2. The Pain Management Flow Sheet will be utilized, when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions (see Appendix B). This initiation is based upon evidence gathered

using the Caressant Care (CC) Pain Assessment tool to ensure that those with identified pain are monitored and that pain is brought under control."

A) The current care plan in Point Click Care (PCC) for an identified resident stated the resident had pain from two specified sites. An intervention documented, "Complete pain assessments to monitor effectiveness of pain control measures as per policy and procedure (P&P)".

The progress notes in PCC for the identified resident over the course of one month stated there were eight specified dates where the identified resident experienced pain ranging from a pain score of seven to nine.

The quarterly Caressant Care "CC Pain Assessment Tool" stated the identified resident had complaints of pain and that they were satisfied with a pain score of five. This was the only "CC Pain Assessment Tool" completed since October 2017.

In an interview, the Registered Practical Nurse (RPN) verified that the CC Pain Assessment Tool should be completed when a resident complained of pain of "four" or greater. The RPN reviewed the progress notes for pain with the inspector and the RPN reported there were eight specified dates that a CC Pain Assessment Tool was not completed and should have been completed for the identified resident's complaint of pain.

B) The current care plan in Point Click Care (PCC) for a second identified resident stated the resident had pain due to a medical diagnosis. An intervention documented, "Complete pain assessments to monitor effectiveness of pain control measures as per policy and procedure (P&P)".

In an interview, the identified resident pointed to where their pain was and told the inspector they had excruciating pain all the time. The identified resident stated they required pain management medication.

The progress notes in PCC for the identified resident over a one month period, stated the resident complained of three episodes of unrelieved pain on the same day.

The Caressant Care "CC Pain Assessment Tool" dated January 2018, stated the identified resident was able to identify the cause of their pain and that the identified

resident was satisfied with a pain level of five. This was the only "CC Pain Assessment Tool" completed since October 2017.

In an interview, the RPN verified that the expectation according to the Pain Assessment policy for a resident who reported an unresolved pain score of "10/10" after the administration of a pain medication was to complete the CC Pain Assessment Tool and document the pre and post pain scale scores in PCC. The RPN verified that the CC Pain Assessment Tool was not completed in PCC for the identified resident's complaints of "10/10" pain on the specified date.

In an interview, the Executive Director (ED) acknowledged that a CC Pain Assessment Tool was to be completed in PCC according to the home's "Pain Assessment" policy for the two identified residents.

C) Compliance Order #001 from Follow-up Inspection #2017_536537_0040, ordered the following: "The licensee must achieve compliance to ensure that the home's policy "Pain Assessment" is complied with. Specifically, the licensee will ensure that all direct care staff receive education related to the Pain Assessment policy".

The home's Pain Assessment policy with review date May 2015 stated, "The Pain Management Flow Sheet will be utilized, when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions (see Appendix B). This initiation is based upon evidence gathered using the Caressant Care (CC) Pain Assessment tool to ensure that those with identified pain are monitored and that pain is brought under control."

In an interview the Director of Nursing (DON) stated that the pain education was completed related to the compliance order.

Review of the "Pain" education forms signed by the registered nursing staff showed the direction provided in this education did not match the documentation expectations as part of the Pain Assessment policy as it did not outline direction related to the Pain Management Flow Sheet.

Review of the program binder included education resources titled "Pain Management" and the "Pain Assessment" policy located at the front of the program binder. Appendix A and Appendix B as described in the Pain Assessment policy were absent.

In an interview the Executive Director (ED) stated that the "Pain Management" form and the "Pain Assessment" policy located at the front of the program binder were the resources used to educate the direct care staff. The ED acknowledged that there was not a copy of "Appendix A" and "Appendix B" as documented in the Pain Assessment policy and could not verify if "Appendix A" and "Appendix B" were part of the education delivered to the direct care staff. The ED stated that Appendix A was the CC Pain Assessment Tool and Appendix B was the Pain Management Flow Sheet.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) and the Registered Nurse (RN) acknowledged that the Pain Management Flow Sheet was not utilized and had never been used by either of them. The RN stated they were hired in the past month and as part of the new staff orientation, the pain assessment policy was reviewed; they said they had never seen the Pain Management Flow Sheet before.

In an interview the RAI-C acknowledged that they had to find a copy of the Pain Management Flow Sheet as it was not readily available for use by the registered staff.

In an interview, an RPN stated the Pain Management Flow Sheets were no longer utilized. They stated that the Pain Management Flow Sheets were replaced with pre and post pain scale scores to be documented in PCC under the Weights and Vitals tab and that the direction came from the DON. The RPN stated that they reviewed the Pain Assessment policy as part of the pain education, but the Pain Management Flow Sheet was not reviewed.

Registered nursing staff verified that the home's policy was not followed related to the completion of the Pain Management Flow Sheet when a scheduled pain medication did not relieve the pain or when pain remained regardless of interventions. The same registered nursing staff shared that the Pain Management Flow Sheet was no longer used by the home.

The licensee has failed to ensure that the Pain Assessment policy was complied with. The licensee was to achieve compliance by specifically ensuring that a CC Pain Assessment Tool in PCC was completed when identified residents complained of pain with a scale score of “four or greater” and when identified residents pain scale score of “10/10” was unrelieved. The licensee was to ensure

that all direct care staff received education related to the Pain Assessment policy, but this education did not include all forms and assessments required for completion documented as Appendix A and Appendix B as part of the policy that was implemented by the licensee. [s. 8. (1) (b)]

Additional Required Actions:

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

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Observations completed in stage one and stage two of the Resident Quality Inspection (RQI) showed an identified resident was wearing a safety device.

In an interview the identified resident stated that it was their preference to wear the safety device when using their assistive device.

Review of the clinical record for the identified resident did not show evidence documented of the resident's preference to wear the safety device.

In interviews the Personal Support Worker (PSW) stated the identified resident requested to wear the safety device when they got them up in the morning.

In an interview the RAI (Resident Assessment Instrument) Coordinator acknowledged that there was no documentation related to use of a safety device in the the identified resident's plan of care.

The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

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.

In an interview, Resident Assessment Instrument Coordinator (RAI-C), stated that an identified resident had fallen on a specified date. The RAI-C shared that the fall was witnessed.

The "Incident" progress note for the witnessed fall, documented that identified resident slid out of their assistive device.

The "Physiotherapy" progress note documented a post fall assessment for the witnessed fall. The Physiotherapist (PT) updated the care plan in Point Click Care (PCC) to include a falls prevention safety intervention for use of specified equipment.

Observations of the identified resident's room showed there was no specified

equipment in place in the resident's room.

In an interview a Personal Support Worker (PSW) stated they did not remember the identified resident ever using the specified equipment. The PSW looked in Point of Care (POC) in the kardex for safety interventions related to falls prevention. They verified that the kardex identified the specified equipment was to be utilized and acknowledged that there was no equipment provided to the identified resident as set out in the plan of care.

In interviews, Physiotherapist (PT) and Physiotherapist Aide (PTA) shared they could not recall if the specified equipment was in place when they last worked with the resident. The PT verified that they added the safety equipment to the resident's care plan and acknowledged that the intervention was not communicated to anyone in order to ensure
the intervention be put in place.

In an interview, Restorative Aide (RA) shared that whenever an intervention was put in place for equipment, the Registered Nurse (RN) or Director of Nursing (DON) would be notified and would follow up with implementing the intervention.

The licensee has failed to ensure that the falls prevention strategy with the use of specified equipment set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

A staff interview and MDS (Minimum Data Set) information for an identified resident showed that the resident had a device in place.

Review of the progress notes for the identified resident showed the device was ordered in the past year.

Review of the resident's electronic Medication Administration Record (eMAR) showed a physician order for the frequency of the change of the device. Review of the eMAR showed the device change that was scheduled for December 2017 was not signed by a registered staff member as being completed.
In an interview with the identified resident, they stated that they could not recall when the device was last changed or who had changed it.

In an interview and review of the resident's clinical records, Resident Assessment Instrument Coordinator (RAI-C) acknowledged the device change for December 2017 had not been signed for on the eMAR and they stated that if it was not signed it was assumed that it had not been completed.

In an interview the Registered Nurse, who was scheduled to work on date the device change was due said that they had completed the device change but did not sign the eMAR, therefore they could not provide documented outcomes of the care provided to the identified resident.

The Executive Director (ED) acknowledged that undocumented care would not support that the care was provided, and therefore did not support documented outcomes of care for the resident. [s. 6. (9) 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 the residents' plans of care are based on an assessment of the resident's needs and preferences; the care set out in the plan of care is provided to the resident as specified in the plan and that the outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation:
Ontario Regulation 79/10, s. 48 (1) 4 states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a pain management program to identify pain in residents and manage pain.

Ontario Regulation 79/10, s.30 (3) states "the program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

In an interview, Executive Director (ED) shared that there was no documented

evidence that a Pain Management Program Evaluation was completed for 2017. The ED shared that the program binder was reviewed and they were unable to locate the document.
The licensee has failed to ensure that the Pain Management Program was evaluated and updated at least annually. [s. 30. (1) 3.]

2. The licensee has failed to ensure that the following was complied with in respect of each of the of the interdisciplinary program evaluations: the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A. Ontario Regulation 79/10, s. 48 (1) 2 states " Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions".

In review of the home's Skin and Wound Care Management Program Evaluation, with a service review from October 2016 to October 2017, there was no documentation of the date the evaluation was completed.

A documentation of the summary of changes included: "all residents swabbed in order to update binder; complex wounds changed to day shift in order to better monitor by wound champion". The summary of changes made did not include the date that the changes were implemented.
There was no other documentation to identify the date the change was implemented.

In an interview, the Executive Director (ED) acknowledged there were no documented dates for the evaluation nor were there dates documented related to the summary of changes made to the program.

B.Ontario Regulation 48.(1) 1 states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the "Fall Prevention/Resident Safety Plan Program Evaluation" with a service review from October 16, 2016 to May 31, 2017, documented the summary

of changes as, “education regarding proper use of restraints to identified residents” and “30 percent (%) of resident population attend daily exercise groups 6 times/week.” There was no other documentation to identify the date the changes were implemented.

Review of the "Fall Prevention/Resident Safety Plan Program Evaluation" with a service review from May 2016 to May 2017 documented the summary of changes as, "Restorative and physio now working together." There was no other documentation to identify the date the change was implemented.

In an interview Physiotherapy Aide (PTA) verified that they attended both program evaluations as part of the Fall Prevention Program and they clarified that Restorative Care and Physiotherapy were working together for those residents who required two staff participation for the walking program. The PTA shared that the collaboration between physio and restorative started on April 2017.

In an interview Executive Director (ED) acknowledged that there were no dates documented of the summary of changes as part of the fall prevention program evaluation and there should be since the staff members involved in the evaluation had the dates required for the completion of this section.
The licensee has failed to ensure that the following was complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation: to keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an evaluation and annual update of the Pain Management program will be completed and that when an evaluation of the interdisciplinary programs required under sections 48 of the Regulation is completed, the date of the evaluation will documented as well as the date for the summary of changes will be documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident at risk of exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Review of the clinical record showed an identified resident was transferred and admitted to hospital and discharged back to the home.

Review of the PCC assessments and skin and wound module for the identified resident showed the identified resident had not had a skin and wound assessment documented until one week after readmission to the home.

In an interview, a Registered Practical Nurse (RPN), the Wound Care Champion and interim Director of Nursing stated that the skin and wound assessments were missed. The expectation was that a head to toe assessment and a skin and wound assessment should have been completed upon the identified resident's readmission to the home.

The Executive Director (ED) and interim DON acknowledged that a skin and wound assessment had not been completed by a member of the registered nursing staff upon identified resident's return from hospital.

The licensee failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital. [s. 50. (2) (a) (ii)].

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. A review of an identified resident's clinical record showed that the resident had impaired skin integrity.

A review of the home's Wound Assessment policy documented "all residents with skin and wound issues shall have these areas assessed by registered nursing staff every 7 days." The procedure documented the minimum information that was to be documented related to each wound.

Review of the documented Skin and Wound assessments on PCC showed that over a specified eight week period there were three weekly assessments that had

not been documented for the identified resident.

In an interview Resident Assessment Instrument Coordinator (RAI-C) and Registered Practical Nurse said that impaired areas were assessed weekly and documented in PCC Skin and Wound Care Module.

The RAI Coordinator reviewed the identified resident's weekly wound assessments under the skin and wound tab in PCC and acknowledged that skin and wound assessments had not been documented weekly during the specified eight week period.

B. Review of the clinical record from PCC Skin and Wound module for an identified resident showed the resident had three documented areas of impaired skin integrity.

A review of PCC Skin and Wound Care Module for the identified resident for six week period showed that an assessment had not been completed on a specified date.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) stated RPNs were responsible for signing skin and wound care treatments off in the electronicTreatment Assessment Record (eTAR) daily.

A review of the clinical record and PCC skin and wound module for identified resident was completed with a Registered Practical Nurse (RPN) and Wound Care Champion; they stated there was not an assessment of the impaired skin area and no measurements or photo of the impaired skin area, as per their policy for one specified date.

In an interview, the Executive Director (ED) acknowledged that the identified resident had not received a weekly skin and wound assessment by a member of the registered nursing staff.

C. Review of the clinical record for an identified resident for an eight week period, as documented on the Point Click Care (PCC) skin and wound module showed four impaired skin areas.

Clinical documentation for the identified resident showed skin and wound assessments had not been completed for three of the four impaired skin areas on

two specified dates.

In an interview with Registered Practical Nurse (RPN) and Wound Care Champion, they acknowledged that the resident had not had a weekly skin and wound assessment.

In an interview and documentation review the Executive Director (ED) acknowledged the identified resident had not received weekly skin and wound assessments by a member of the registered staff.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents at risk of exhibiting altered skin integrity will receive a skin assessment by a member of the registered nursing staff upon any return from hospital as well residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that corrective action was taken as necessary for all medication incidents and adverse drug reactions.

As part of the Resident Quality Inspection (RQI), a review of medication incidents for a specified quarter was completed.

Three medication incident reports were selected and reviewed. Two of the medication incident reports documented that staff missed administering scheduled doses of medication to two identified residents on specified dates.

The third medication incident report identified that staff administered an as needed (PRN) medication too close to a scheduled dose of medication.

The home's medication incident report and risk management report did not include written corrective action for any of the medication incidents reviewed.

During an interview the Executive Director (ED) said that they spoke with Director of Nursing (DON) who had acknowledged that there were no written records of corrective action taken for the three identified medication incidents.

The licensee has failed to ensure that corrective action was taken as necessary related to the identified medication incidents.

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 medication incidents and adverse drug reactions had a written record maintained of corrective action that was taken, to be implemented voluntarily.

WN #6: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following:
Ontario Regulation 79/10 s.221.2 states:1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

Ontario Regulation 79/10 s. 221(1) states that for the purposes of paragraph 6 of subsection 76(7) of the Act, the following are other areas in which training shall be provided to all staff who provided direct care to residents: 2. Skin and wound care.

In interviews, the Resident Assessment Instrument Coordinator (RAI-C) and Registered Practical Nurse (RPN) stated that there had been changes to the skin and wound care program in November 2017. The RPN stated it had been years since they had training related to skin and wound care.

The home was not able to provide documented evidence that all staff who provided direct care to residents received annual training related to skin and wound care.

In an interview, the Executive Director (ED) stated that the education for skin and wound care had not been completed for 2017 for all direct care staff.

The licensee had failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following:1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, related to skin and wound care. [s. 221. (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 direct care staff are provided with annual training in skin and wound care, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and immediate action was taken as required.

Review of the home's policy Signs and Symptoms of Infection, documented: "time must be spent familiarizing all nursing staff with the signs/symptoms of infections to assist them in recognizing changes in the resident's health status that may indicate the presence of an infection. Once a sign or symptom has been identified, it should be reported to the staff member in charge and/or the Infection Control officer and documented in the resident's chart".

A) Review of the outbreak control measures documented for an outbreak during a specified time period showed a case definition which included five symptoms.

An identified resident was line listed on day shift of a specified date, with symptoms which related to the outbreak case definition.

Review of the clinical record on Point Click Care (PCC) for the identified showed over a specified three day period the identified resident's vitals and symptoms were documented at least once a day but not once a shift. The resident was removed from the monitoring list on the third day, but the clinical record showed on the fourth day a note was added to the physician's book to assess the resident for

continued symptoms.

The clinical record showed the identified resident was assessed by the physician and orders initiated for antibiotic therapy for an infection.

B) Review of the clinical record for an identified resident showed the resident had a history of a specific infection. The identified resident was admitted to hospital and treated for the infection, and later returned to the home on antibiotic therapy.

Review of progress notes on Point Click Care (PCC) following the resident's return from hospital showed vital signs and a progress note entry were completed on four of eight shifts following the resident's readmission from hospital. On the third day, the resident was assessed with symptoms of a different infection which met the case definition for the outbreak and they were line listed as part of the outbreak; no further documented entries were noted related to the resident's initial infection.

In an interview, the Resident Assessment Instrument Coordinator (RAI-C) stated that the home's process was to document signs and symptoms of an infection in the resident's progress notes or the 24 hour communication log. When a resident returned from hospital, they were to have a progress note completed each shift and vitals were to be taken.

The RAI-C later said there was an "Isolation worksheet" which documented residents who were being observed for one symptom and if a resident had two or more symptoms they should be placed on the surveillance tracking; the RAI-C stated that staff on each shift were to record vitals.

In an interview Registered nurse (RN) stated this isolation worksheet was used to determine if the resident had an infection. A review of the worksheet documentation provided for two specified dates showed documentation of vital signs on each shift for residents listed. The document did not include symptoms of infection.

The RAI-C, RN and Executive Director acknowledged that the isolation worksheets had not been maintained by the home and that they only had documentation for the two specified dates provided to the inspector.

The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and take immediate action was taken as required. [s. 229. (5)

(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 there is a process in place to monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and how staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

Issued on this 31 day of May 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JANETM EVANS (659) - (A1)

Inspection No. / No de l'inspection : 2018_363659_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 001163-18 (A1)

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

Report Date(s) / Date(s) du Rapport : May 31, 2018;(A1)

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 Mary Bucke
4 Mary Bucke Street, ST. THOMAS, ON, N5R-5J6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kori Amon

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_536537_0040, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8.(1)(b) of the Regulation.

The licensee must prepare, submit and implement a written plan for achieving compliance to ensure that the home's "Pain Assessment" policy is complied with.

Specifically, the licensee will:
a) Ensure the Pain Assessment policy with a review date of May 2015 is reviewed and revised with respect to monitoring of residents' response to, and the effectiveness of, the pain management strategies as well as any tools or assessments required to be completed.
b) Ensure all staff who provide care direct care to residents are trained on the revised Pain Assessment policy.
c) Ensure there is a record of all of the staff who were trained on the revised Pain Assessment policy.
d) Ensure the revised Pain Assessment policy is implemented and complied with.

Please submit the written plan for achieving compliance for inspection 2018_363659_0003 to Janet Evans, LTC Homes Inspector, MOHLTC, by email : LondonSAO.MOH@ontario.ca by April 18, 2018.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance order #001 from inspection #2017_536537_0040 served on Nov 15, 2017 with a compliance date of December 29, 2017.

The licensee was ordered to achieve compliance to ensure that the home's "Pain Assessment" policy was complied with.

Specifically, the licensee will:
a) Ensure a Pain Assessment is completed when:
- a resident's pain is not relieved by initial interventions
- a new pain medication is initiated,
- a resident exhibits behaviour that may herald the onset of pain,
- a resident complains of pain of 4 or greater,
- a resident exhibits distress related behaviours or facial grimace,

- a resident/family/staff/volunteers indicate pain is present,
- a resident has new or worsening pain or if a resident indicates pain is present, and
- a resident who scores a two or higher on any RAI MDS assessment under section J2 2.

b) Ensure that all direct care staff receive education related to the Pain Assessment policy.
c) Ensure that an identified resident receives a pain assessment with the initiation of a new medication.

The licensee completed step c).
The licensee failed to complete steps a) and b).

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s. 30 (1) states, that "every licensee shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required".

Ontario Regulation 79/10, s. 52 (1) states that "the pain management program must, at a minimum, provide for the following: 4. Monitoring of residents' response to, and the effectiveness of, the pain management strategies".

The home's Pain Assessment policy with review date May 2015 stated the following: "1. Caressant Care recognizes that RAI MDS as a comprehensive assessment. Residents who score a two (2) or higher on any Minimum Data Set Resident Assessment Instrument (MDS-RAI) assessment under section J2 will have a further pain assessment completed using the Caressant Care Pain Assessment Tool on Point Click Care (see Appendix A). This assessment will also be utilized when: a new medication is initiated, a resident exhibits behaviour that may herald the onset of pain, a resident complains of pain of four or greater, a resident exhibits distress

related behaviours or facial grimace, a resident/family/staff/volunteers indicate pain is present.

2. The Pain Management Flow Sheet will be utilized, when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions (see Appendix B). This initiation is based upon evidence gathered using the Caressant Care (CC) Pain Assessment tool to ensure that those with identified pain are monitored and that pain is brought under control."

A) The current care plan in Point Click Care (PCC) for an identified resident stated the resident had pain from two specified sites. An intervention documented, "Complete pain assessments to monitor effectiveness of pain control measures as per policy and procedure (P&P)".

The progress notes in PCC for the identified resident over the course of one month stated there were eight specified dates where the identified resident experienced pain ranging from a pain score of seven to nine.

The quarterly Caressant Care "CC Pain Assessment Tool" stated the identified resident had complaints of pain and that they were satisfied with a pain score of five. This was the only "CC Pain Assessment Tool" completed since October 2017.

In an interview, the Registered Practical Nurse (RPN) verified that the CC Pain Assessment Tool should be completed when a resident complained of pain of "four" or greater. The RPN reviewed the progress notes for pain with the inspector and the RPN reported there were eight specified dates that a CC Pain Assessment Tool was not completed and should have been completed for the identified resident's complaint of pain.

B) The current care plan in Point Click Care (PCC) for a second identified resident stated the resident had pain due to a medical diagnosis. An intervention documented, "Complete pain assessments to monitor effectiveness of pain control measures as per policy and procedure (P&P)".

In an interview, the identified resident pointed to where their pain was and told the inspector they had excruciating pain all the time. The identified resident stated they required pain management medication.

The progress notes in PCC for the identified resident over a one month period, stated the resident complained of three episodes of unrelieved pain on the same day.

The Caressant Care "CC Pain Assessment Tool" dated January 2018, stated the identified resident was able to identify the cause of their pain and that the identified resident was satisfied with a pain level of five. This was the only "CC Pain Assessment Tool" completed since October 2017.

In an interview, the RPN verified that the expectation according to the Pain Assessment policy for a resident who reported an unresolved pain score of "10/10" after the administration of a pain medication was to complete the CC Pain Assessment Tool and document the pre and post pain scale scores in PCC. The RPN verified that the CC Pain Assessment Tool was not completed in PCC for the identified resident's complaints of "10/10" pain on the specified date.

In an interview, the Executive Director (ED) acknowledged that a CC Pain Assessment Tool was to be completed in PCC according to the home's "Pain Assessment" policy for the two identified residents.

C) Compliance Order #001 from Follow-up Inspection #2017_536537_0040, ordered the following: "The licensee must achieve compliance to ensure that the home's policy "Pain Assessment" is complied with. Specifically, the licensee will ensure that all direct care staff receive education related to the Pain Assessment policy".

The home's Pain Assessment policy with review date May 2015 stated, "The Pain Management Flow Sheet will be utilized, when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions (see Appendix B). This initiation is based upon evidence gathered using the Caressant Care (CC) Pain Assessment tool to ensure that those with identified pain are monitored and that pain is brought under control."

In an interview the Director of Nursing (DON) stated that the pain education was completed related to the compliance order.

Review of the "Pain" education forms signed by the registered nursing staff showed the direction provided in this education did not match the documentation expectations as part of the Pain Assessment policy as it did not outline direction related to the Pain Management Flow Sheet.

Review of the program binder included education resources titled "Pain Management" and the "Pain Assessment" policy located at the front of the program binder. Appendix A and Appendix B as described in the Pain Assessment policy were absent.

In an interview the Executive Director (ED) stated that the "Pain Management" form and the "Pain Assessment" policy located at the front of the program binder were the resources used to educate the direct care staff. The ED acknowledged that there was not a copy of "Appendix A" and "Appendix B" as documented in the Pain Assessment policy and could not verify if "Appendix A" and "Appendix B" were part of the education delivered to the direct care staff. The ED stated that Appendix A was the CC Pain Assessment Tool and Appendix B was the Pain Management Flow Sheet.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) and the Registered Nurse (RN) acknowledged that the Pain Management Flow Sheet was not utilized and had never been used by either of them. The RN stated they were hired in the past month and as part of the new staff orientation, the pain assessment policy was reviewed; they said they had never seen the Pain Management Flow Sheet before.

In an interview the RAI-C acknowledged that they had to find a copy of the Pain Management Flow Sheet as it was not readily available for use by the registered staff.

In an interview, an RPN stated the Pain Management Flow Sheets were no longer utilized. They stated that the Pain Management Flow Sheets were replaced with pre and post pain scale scores to be documented in PCC under the Weights and Vitals tab and that the direction came from the DON. The RPN stated that they reviewed the Pain Assessment policy as part of the pain education, but the Pain Management Flow Sheet was not reviewed.

Registered nursing staff verified that the home's policy was not followed related to the completion of the Pain Management Flow Sheet when a scheduled pain medication did not relieve the pain or when pain remained regardless of interventions. The same registered nursing staff shared that the Pain Management Flow Sheet was no longer used by the home.

The licensee has failed to ensure that the Pain Assessment policy was complied with. The licensee was to achieve compliance by specifically ensuring that a CC Pain Assessment Tool in PCC was completed when identified residents complained of pain with a scale score of "four or greater" and when identified residents pain scale score of "10/10" was unrelieved. The licensee was to ensure that all direct care staff received education related to the Pain Assessment policy, but this education did not include all forms and assessments required for completion documented as Appendix A and Appendix B as part of the policy that was implemented by the licensee.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 5 history as they had on-going non-compliance with this section of the legislation that included:
- a Voluntary Plan of Correction (VPC) issued on June 11, 2015 (2015_355588_0015).
-Compliance order #001 issued on April 13, 2016 with a compliance due date of June 7, 2017 (2016_326569_0005).
-Compliance order #001 issued on June 9, 2017,with a compliance due date of July 28, 2017 (2017_606563_0009)
-Compliance order #001 issued on November 15, 2017, with a compliance due date of December 29, 2017 (2017_536537_0040).
(563)

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

Jul 27, 2018(A1)

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

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

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

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

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

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

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 31 day of May 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JANETM EVANS - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Service Area Office / Bureau régional de services : London