Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2020	2020_722630_0002 (A2)	021332-19, 023295-19, 023534-19, 023894-19, 001138-20	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date (CDD) of April 30, 2020, for CO #002 regarding s. 8 (3) of the LTCHA related to 24/7 RN staffing has been extended to October 31, 2020, at the direction of the Director. This change is being made as CO #002 is impacted by the Emergency Orders due to the COVID-19 pandemic under Subsection 7.0.2(4) of the Emergency Management and Civil Protection Act and specifically the Order under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes which was signed March 27, 2020.

Issued on this 14th day of July, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Amended by AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 6, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21 and 22, 2020.

The following Complaint intakes were completed within this inspection:

Log #023894-19 / IL-72992-LO related to the home's Falls Management Policy and procedures;

Log #021332-19 / IL-71805-LO related to Registered Nurse (RN) staffing, availability of mobility aids, refrigerator temperatures and processing physician's orders;

Log #023295-19 / IL-72757-LO related to Registered Nurse (RN) staffing;

Log #023534-19 / IL-72834-LO related to Personal Assistive Services Devices (PASD) assessments and plan of care and the home's process for dealing with complaints;

Log #001138-20 / IL-73812-LO related to smoking safety.

Documentation of non-compliance related to Log #023894-19 has been documented within Follow-Up Inspection #2020_722630_0001.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant ED, the OMNI Lead, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Food and Nutrition Manager (FNM), Resident Care Coordinators (RCCs), a Physiotherapist (PT), a Maintenance staff member, Human Resource Manager Gifted Hands Agency, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs) family members and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes, reviewed the home's written staffing plan

related to RN staffing, reviewed recommendations provided to the home by OMNI, reviewed Public Health Unit reports, reviewed refrigerator temperature records and also reviewed the Caressant Care Woodstock Compliance Plan of Corrective Action.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

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

- **5 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A) The Ministry of Long-Term Care (MOLTC) received two anonymous complaints related to a resident smoking in the home. The complainants expressed concern that there was a specific resident with unsafe smoking practices, which placed the other residents in the home at risk.

The clinical record for this specific resident included documentation that staff had

identified unsafe smoking practices and risks related to smoking on multiple occasions. The clinical record included one smoking assessment that had been completed at admission and no smoking reassessments. The plan of care provided specific directions for staff and the documentation showed this had not been consistently followed or updated when the interventions were not effective.

During an interview the specific resident told Inspector #730 about their smoking practices in the home.

During observations the inspectors identified that specific interventions in the plan of care for this resident were not complied with.

During interviews with staff they said residents in the home were not allowed to keep cigarettes or lighters in their room. The staff said there were specific interventions in place for this resident.

During an interview with the Director of Care (DOC) and Assistant Director of Care (ADOC) they said the home had a policy related to smoking was the one which was titled "Smoking - Policy for Residents and Staff." They said this specific resident had been educated on the policy and was told there would be specific interventions if they continued to not comply with the policy. They said this resident had specific behaviours related to their smoking practices and there were specific interventions in place. They acknowledged that there were specific parts of the home’s policy and the plan of care for this resident which were not complied with.

During an interview the Executive Director (ED) said the home had not sent this resident a letter, as per the home’s policy related to their non-compliance with the home’s smoking policy.

B) Another specific resident was identified as a smoker through a review of the “Assessment Report” in PCC, which showed that “Smoking Assessments” had been completed for this resident on a specific dates.

A review of the plan of care for this resident found it included specific interventions related to smoking safety.

During an interview the specific resident told Inspector #563 about their smoking practices in the home.

During observations the inspectors identified that specific interventions in the plan of care for this resident were not complied with.

During an interview a staff member said there were no cigarettes stored in the medication room for this resident. They said that they thought that residents who were responsible smokers could keep cigarettes in their room or on their person.

The licensee has failed to ensure that the home was a safe environment for all residents due to the safety risks related to a specific resident's smoking practices and the inconsistent implementation by staff of the plan of care and the home's smoking policy. [s. 5.] (730)

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint that there was no Registered Nurse (RN) in the home on a specific shift in December 2019.

The MOLTC received another anonymous complaint related to insufficient RN staffing levels in the home and that there had been times where there was no RN in the building on a specific shift in November 2019.

The Long Term Care Homes Act, 2007 s. 8 (3) refers "regular nursing staff" which means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

Gifted Hands Health Services and TLC Health Services were the agencies used by Caressant Care Woodstock (CCW) for both RNs and Registered Practical Nurses (RPNs).

The Caressant Care Nursing Home Staff Assignment Sheets indicated the planned staffing level in the home was three RNs on the day shift, two RNs on the evening shift and one RN on the night shift. The Caressant Care Nursing Home Staff Assignment Sheets and the Daily Assignment Reports dated November 1, 2019 to December 8, 2019 were reviewed for the time between the two reported complaints. The home did not have an RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home on 12 specific dates.

The current Caressant Care Nursing Home Staff Assignment Sheets and the Daily Assignment Reports dated January 1 to 15, 2020 was also reviewed. The home did not have an RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home on three specific dates.

During interviews with staff it was identified that there were specific shifts when the RN in the building was working through an agency.

During an interview the Director of Care (DOC) verified that for the specific dates the home used an agency RN on the evening and/or night shift with no other RN

who was both an employee of the home and a member of the regular nursing staff on duty and present in the home.

During an interview the Assistant Director of Care (ADOC) stated they had worked the night shift as the RN on duty at times. The ADOC verified there was not an RN who was a member of the staff of the home also on duty on the evening or night shift on specific shifts.

During an interview the Executive Director (ED) stated there were three RNs on the day shift to be at full complement for RN staff according to the staffing plan. The ED stated the staffing plan at full complement of RN staff for the evening shift included two RNs and for the night shift the plan included one RN. The ED verified they were aware that there were shifts where there was no RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home, and agency RNs were on duty who were familiar with the residents and routines.

The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times on specific dates in November and December 2019, and January 2020. [s. 8. (3)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care for specialized interventions related to the residents' bed systems, were based on an interdisciplinary assessment.

A) The Ministry of Long-Term Care (MOLTC) received a complaint related to a family member's concern that a specific device had been removed from a resident's bed at a specific time. The complainant indicated that they felt the resident required this device for specific reasons and felt they had not been properly assessed by an interdisciplinary team.

Inspector #630 observed this resident's bed system and identified which interventions were in place at the time of the inspection.

During an interview the Assistant Director of Care (ADOC) said they started working in the home in July 2019 and after that they became familiar with the home's program and interventions related to bed mobility and bed systems. They said they had identified a concern with the use of a specific type of device in the home and between a specific time frame the bed systems for all residents were reviewed and this device removed. The ADOC said based on the assessment some residents no longer had a device in place while others had a new type of device implemented as part of their plan of care. The ADOC said they were not familiar with the process in the home prior to this change for assessing the bed systems, including the use of this device. The ADOC acknowledged that there had been inconsistencies and gaps in the assessments and plan of care for residents in the home related to the use of this bed mobility device. The ADOC said staff in the home had been using the terms for different devices interchangeably. The ADOC said the home was in the process of reviewing and revising the policies related to Personal Assistive Services Devices (PASDs) including devices for bed mobility. The ADOC said the process in the home at the time of the inspection was that the Physiotherapist (PT) had been doing the assessments and the home was in the process of implementing a nursing

assessment as part of the assessment and they were waiting for the corporate office to implement.

When asked specific questions about this resident, the ADOC said they were familiar with this resident and had been involved in assessing the resident's bed mobility and the changes made to their special interventions. The ADOC acknowledged that the device that was in place had not been assessed by the interdisciplinary team or included in the plan of care when it was added as an intervention after the resident was admitted to the home. The ADOC said interdisciplinary assessments had been completed at specific times. The ADOC said they thought the family for this resident wanted a specific type of device to be assessed, but that device was not an intervention available to be used in the home for specific reasons. The ADOC acknowledged that this resident had a specific type of specialized mattress in place and this had not been assessed and was not included in the plan of care.

The clinical record for this resident showed a specific device had been added to the resident's bed system on a specific date. The record did not include a documented assessment for the use of a specific type of assistive device until five months after it had been implemented. The plan of care for this resident since admission to the home did not consistently include the special devices in place for bed mobility.

During an interview with a registered nursing staff member they said this resident had a specific device in place for a specific reason and there had been changes made to the interventions. They said the resident required a specific type of assistance from staff with bed mobility.

During an interview the Physiotherapist (PT) said they had started in the home in August 2019 and soon after they had started they were asked to assess specific residents for their bed mobility and use of PASDs. The said they documented these assessments in the progress notes. They said that based on these assessments they made recommendations and then the nursing team was responsible for updating the plan of care. The PT said they had assessed this specific resident and had made specific recommendations.

During an interview the Executive Director (ED) said the management had identified a risk with the use of a specific type of device in the home and had taken action to reduce the risk for residents. The ED said the home was working

to review and revise the polices related to PASD and the use of these devices. The ED said the current policy in the home did not provide direction for staff related to the assessments of these specialized devices, apart from those considered to be a restraint. The ED said it was the expectation in the home that specialized interventions would be assessed by the interdisciplinary team and included in the plan of care.

B) Inspector #630 observed that another identified resident had specific interventions in place related to bed mobility.

During an interview this resident stated they had a specific concern about their bed system.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During an interview with staff they said this resident required a specific type of assistance from staff with bed mobility and specific specialized devices in place. They said they were not sure which devices were in place at the time of the inspection.

During an interview the ADOC said they were familiar with this resident. The ADOC said the plan of care for resident did not identify the specialized type of mattress that was used by the resident. The ADOC said there had been changes made to the resident's bed system and acknowledged prior to the change it was unclear what assessment had been completed by the interdisciplinary team related to the devices in place.

C) During an interview with another identified resident they said they had a change in their mattress and the devices on their bed. The resident said they did not think they had a special mattress and they had a specific device in place on their bed. The resident said they wanted specific changes made to the devices on their bed and had told that to someone in the home. The resident and Inspector #630 observed their bed system and the resident acknowledged that there was a specific type of mattress on the bed and the resident said they thought everyone had that type in the home.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During separate interviews with a registered nursing staff member, the PT and the ADOC they said they were familiar with this resident and they required a specific type of assistance from staff with bed mobility. They said specific changes had been made to this resident's bed system and assessments for specific things had not been done.

D) Inspector #630 observed that another specific resident's bed had a specific device in place.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During an interview the ADOC said they were familiar with this resident and they used a specific type of device to assist with bed mobility. The ADOC was unsure how long the device had been in use and they were unable to find an assessment of the use of this device.

During an interview the PT said they had been involved in assessing this resident on a specific date for the use of a specific device. The PT said they had no prior involvement in assessing this resident for the use of this intervention.

E) Inspector #630 observed another resident's bed system and identified it had a specific type of specialized mattress.

The clinical record for this resident did not include an assessment of this specialized mattress or include it as an intervention in the plan of care.

During an interview the ADOC said this resident had a specific type of specialized mattress on their bed. The ADOC acknowledged this was not included in the plan of care and the resident had not been assessed for this specialized intervention and said they did not know if there was a specific purpose for the mattress for this resident.

Upon request, the ED provided the manufacture's specification for this specialized mattress that was used in the home. The document indicated the mattresses had a specific name and identified the special purposes for this mattress. The ED said they were aware that home did have specialized mattresses that were in use. The ED said these had been in place prior to them starting in their role and they were looking into why they were purchase and the intended purpose. The ED said the priority in the home had been addressing and mitigating the potential risk related to a specific type of device and they were working to make further changes and improvements related to the use of PASDs in the home.

Based on observations, interviews and record review the specialized bed system interventions that were in place for residents had not been consistently assessed by the interdisciplinary team in the home and were not consistently included in the plan of care. The homes' written polices and procedures for assessing and implementing specialized interventions was in the process of being reviewed and revised, and at the time of the inspection it did not provide clear direction to staff regarding the process for the interdisciplinary assessments and care planning. [s. 26. (3) 18.] (630)

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with LTCHA, 2007 s.11 (1)(a), and in reference to O. Reg. 79/10 s. 68 (2)(a) the licensee is required to have an organized program of nutrition care and dietary services that provides policies and procedures relating to nutrition care and dietary services and hydration in the home.

Specifically, staff did not comply with the licensee's "Refrigerator Temperature Control" policy (reviewed May 2019), which was part of the licensee's nutrition and dietary services program. This policy required dietary staff to record refrigerator temperatures twice daily on the "Daily Fridge Temperatures Form."

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint. The complainant stated that the home had been utilizing a refrigerator which was broken, and that the temperature was not regulated. The complainant stated that food was kept in that refrigerator.

During an interview a Dietary Aide (DA) said that DAs were responsible for checking the temperatures of the refrigerators. The DA said that the refrigerator in the servery was replaced in November after staff noticed that the temperature in the fridge was too high. The DA provided Inspector #730 with the current temperature sheet from the refrigerator in the servery. Upon review of the "Refrigerator Temperatures" sheet, there were no temperatures documented on specific dates.

During an interview the Food and Nutrition Manager (FNM) told Inspector #730 that DAs were to take the temperatures in the fridges first thing in the morning and at night time. Inspector #730 requested that the FNM provide them with the "Refrigerator Temperatures" sheets for specific time frames and areas.

A review of the "Refrigerator Temperatures" sheets found documentation was missing for specific times.

The FNM told Inspector #730 that they were aware that staff had not been recording refrigerator temperatures, as it was an outstanding issue and that they planned to send out discipline letters to staff related to the issue.

During an interview the Executive Director (ED) said that the "Refrigerator Temperatures" policy was part of the home's nutrition care and hydration program. They said that the issues with the refrigerator on the second floor came to their attention through a report from the Health Unit. The ED reviewed the "Refrigerator Temperatures" records and acknowledged that there were some gaps.

A review of a Southwest Public Health "Food Safety Inspection Report" for a specific date, provided to Inspector #730 by the ED, stated the temperature logs throughout facility were sporadic and the inspector was unable to verify continuous adequate temperatures and the temperatures were not adequate in many fridge units. The home was to "ensure potentially hazardous foods are stored at 4 degrees Celsius and lower."

The licensee has failed to ensure that refrigerator temperatures were taken as per the home's policy. [s. 8. (1) (b)] (730)

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 where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee ensures that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments and interventions, were documented.

In accordance with LTCHA s. 15 (1)(c) and 2(c) the licensee shall ensure "there is an organized program of maintenance services for the home" and "the home, furnishings and equipment are maintained in a safe condition and in good state of repair."

Also in accordance with Ontario Regulation 79/10 s. 15 (1) (a) "every licensee of a long-term care home shall ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident."

During an interview the ADOC said an external company had assisted the home to complete assessments of the residents' bed systems for entrapment risk. The ADOC said the assessments had been documented on a spreadsheet titled "Facility Entrapment Report." The ADOC said the home then used the

spreadsheets to document the reassessments that were done after actions had been taken with the results of the company's assessment. The ADOC said they had been involved in doing the re-assessments along with the Maintenance staff. The ADOC acknowledged that the spreadsheet did not identify who had completed the assessment, when they had been completed or the actions taken related to the previous assessments. The ADOC said the most recent documentation of entrapment assessments was on the "Facility Entrapment Report" dated January 14, 2020. The ADOC said this document covered any assessments that had been conducted between September 2019 and January 2020, and acknowledged that this did not identify who had completed the assessments, the date of the assessments or the changes to the interventions. When asked about the assessment for a specific resident who had a change in their bed system, the ADOC said that looking at the spreadsheet they were unable to tell when this assessment had been completed and who had completed the assessment.

Inspector #630 reviewed the "Facility Entrapment Report" for a another resident and it showed that the resident had "failed" the assessment for a specific "zone." The report had nothing documented under the section "reasons failed." The next "Facility Entrapment Report" for this resident documented that the bed system had passed the assessment. There was nothing documented related to the interventions that had been adjusted.

Based on these interviews and record reviews the home's actions taken with respect to assessments, reassessments and interventions related to bed entrapment were not documented. [s. 30. (2)] (630)

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 14th day of July, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A2)
Inspection No. / No de l'inspection :	2020_722630_0002 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021332-19, 023295-19, 023534-19, 023894-19, 001138-20 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 14, 2020(A2)
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 Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Bradley

Ontario

Ministry of Long-Term Care

Ministère 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(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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.5 of the LTCHA.

Specifically the license must:

a) Ensure the home's policies and procedures related to resident smoking are reviewed, revised and fully implemented. The review must ensure the home's policies and procedures provide clear direction to staff regarding: the completion and documentation of resident smoking assessments; the dispensing of cigarettes and lighters by staff in the home; the procedures to follow when a resident is non-compliant with the smoking regulations; and a process to ensure staff are aware of which residents in the home smoke. The licensee must keep a documented record of the review which includes: the changes made to the policy and procedures; who participated in the review, the date the review was conducted; and the dates that the revised policies and procedures were implement in the home.

b) Ensure all staff of the home, including agency staff, complete training on the home's revised policies and procedures related to resident smoking. The home must keep a documented summary record of the training which includes; the names of the staff who completed the training; the percentage of staff who completed the training by the compliance due date; the format for the training; and the content of the training.

c) Ensure the home's revised policies and procedures related to smoking safety are complied with by staff for two specific residents, and any other

resident who smokes.

d) Communicate the revised smoking policies and procedures to Residents' Council and Family Council. There must be a documented record of when and how this was communicated.

e) Ensure staff complete a documented re-assessment of two specific resident's smoking safety and then review and revise their plan of care based on this assessment.

f) Ensure the resident specific smoking plan of care for two specific residents, and any other resident in the home who smokes, is complied with by staff.

g) Develop and implement a documented auditing process to ensure staff are complying with the home's policies and procedures for smoking safety. The home must keep a documented record of the audits which includes: the date completed; who completed the audits; the results of the audits; and what was done with the result of the audit. At least one audit must be completed prior to the compliance due date.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A) The Ministry of Long-Term Care (MOLTC) received two anonymous complaints related to a resident smoking in the home. The complainants expressed concern that there was a specific resident with unsafe smoking practices, which placed the other residents in the home at risk.

The clinical record for this specific resident included documentation that staff had identified unsafe smoking practices and risks related to smoking on multiple occasions. The clinical record included one smoking assessment that had been completed at admission and no smoking reassessments. The plan of care provided specific directions for staff and the documentation showed this had not been consistently followed or updated when the interventions were not effective.

During an interview the specific resident told Inspector #730 about their smoking practices in the home.

During observations the inspectors identified that specific interventions in the plan of care for this resident were not complied with.

During interviews with staff they said residents in the home were not allowed to keep cigarettes or lighters in their room. The staff said there were specific interventions in place for this resident.

During an interview with the Director of Care (DOC) and Assistant Director of Care (ADOC) they said the home had a policy related to smoking was the one which was titled "Smoking - Policy for Residents and Staff." They said this specific resident had been educated on the policy and was told there would be specific interventions if they continued to not comply with the policy. They said this resident had specific behaviours related to their smoking practices and there were specific interventions in place. They acknowledged that there were specific parts of the home's policy and the plan of care for this resident which were not complied with.

During an interview the Executive Director (ED) said the home had not sent this resident a letter, as per the home's policy related to their non-compliance with the home's smoking policy.

B) Another specific resident was identified as a smoker through a review of the "Assessment Report" in PCC, which showed that "Smoking Assessments" had been completed for this resident on a specific dates.

A review of the plan of care for this resident found it included specific interventions related to smoking safety.

During an interview the specific resident told Inspector #563 about their smoking practices in the home.

During observations the inspectors identified that specific interventions in the plan of care for this resident were not complied with.

During an interview a staff member said there were no cigarettes stored in the

medication room for this resident. They said that they thought that residents who were responsible smokers could keep cigarettes in their room or on their person.

The licensee has failed to ensure that the home was a safe environment for all residents due to the safety risks related to a specific resident's smoking practices and the inconsistent implementation by staff of the plan of care and the home's smoking policy. [s. 5.]

The severity of this issue was determined to be a level three as there was actual risk. The scope of the issue was a level two as it was a pattern. The home had a level 2 history as there was previous non-compliance to a previous section of the legislation. (730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2020(A1)

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically, the licensee must:

a) Ensure at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times.

b) Develop, implement and document a process for the leadership team to evaluate the RN staffing levels in the home. This evaluation must include the identification of the availability of RN staff in the home to cover all required shifts, the effectiveness of the written staffing back-up plan for RNs, and the effectiveness of strategies to hire and train new RN staff. The evaluation must be completed weekly and a written record must be kept in the home of everything related to this evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint that there was no Registered Nurse (RN) in the home on a specific shift in December

2019.

The MOLTC received another anonymous complaint related to insufficient RN staffing levels in the home and that there had been times where there was no RN in the building on a specific shift in November 2019.

The Long Term Care Homes Act, 2007 s. 8 (3) refers "regular nursing staff" which means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

Gifted Hands Health Services and TLC Health Services were the agencies used by Caressant Care Woodstock (CCW) for both RNs and Registered Practical Nurses (RPNs).

The Caressant Care Nursing Home Staff Assignment Sheets indicated the planned staffing level in the home was three RNs on the day shift, two RNs on the evening shift and one RN on the night shift. The Caressant Care Nursing Home Staff Assignment Sheets and the Daily Assignment Reports dated November 1, 2019 to December 8, 2019 were reviewed for the time between the two reported complaints. The home did not have an RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home on 12 specific dates.

The current Caressant Care Nursing Home Staff Assignment Sheets and the Daily Assignment Reports dated January 1 to 15, 2020 was also reviewed. The home did not have an RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home on three specific dates.

During interviews with staff it was identified that there were specific shifts when the RN in the building was working through an agency.

During an interview the Director of Care (DOC) verified that for the specific dates the home used an agency RN on the evening and/or night shift with no other RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home.

During an interview the Assistant Director of Care (ADOC) stated they had worked

the night shift as the RN on duty at times. The ADOC verified there was not an RN who was a member of the staff of the home also on duty on the evening or night shift on specific shifts.

During an interview the Executive Director (ED) stated there were three RNs on the day shift to be at full complement for RN staff according to the staffing plan. The ED stated the staffing plan at full complement of RN staff for the evening shift included two RNs and for the night shift the plan included one RN. The ED verified they were aware that there were shifts where there was no RN who was both an employee of the home and a member of the regular nursing staff on duty and present in the home, and agency RNs were on duty who were familiar with the residents and routines.

The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times on specific dates in November and December 2019, and January 2020. [s. 8. (3)]

The severity of this issue was determined to be a level two as there was minimal risk. The scope of the issue was a level three as it was widespread as it affected the whole home. The home had a level 3 history as a there was previous non-compliance related to the same sub-section of the legislation that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 11, 2019 (2019_778563_0032). (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 26 (3).

Specifically the licensee must:

a) Develop documented procedures in the home to ensure the plan of care for each resident is based on the completion of interdisciplinary assessments and re-assessments related to the use of Personal Assistive Services Devices (PASDs) and special interventions for bed mobility. This must include any type of bedrail, assist bar or specialized mattresses available for use by residents in the home.

b) Fully implement the home's procedures related to the completion of interdisciplinary assessments and re-assessments for the use of PASDs and special interventions related to bed mobility, for five specific residents, and any other resident in the home.

c) Ensure the plan of care for five specific residents, and any other resident in the home, is based on their interdisciplinary assessment for the use of PASDs and/or special interventions for bed mobility.

Grounds / Motifs :

1. The licensee has failed to ensure the plan of care for specialized interventions related to the residents' bed systems, were based on an interdisciplinary assessment.

A) The Ministry of Long-Term Care (MOLTC) received a complaint related to a family member's concern that a specific device had been removed from a resident's bed at a specific time. The complainant indicated that they felt the resident required this device for specific reasons and felt they had not been properly assessed by an interdisciplinary team.

Inspector #630 observed this resident's bed system and identified which interventions were in place at the time of the inspection.

During an interview the Assistant Director of Care (ADOC) said they started working in the home in July 2019 and after that they became familiar with the home's program and interventions related to bed mobility and bed systems. They said they

had identified a concern with the use of a specific type of device in the home and between a specific time frame the bed systems for all residents were reviewed and this device removed. The ADOC said based on the assessment some residents no longer had a device in place while others had a new type of device implemented as part of their plan of care. The ADOC said they were not familiar with the process in the home prior to this change for assessing the bed systems, including the use of this device. The ADOC acknowledged that there had been inconsistencies and gaps in the assessments and plan of care for residents in the home related to the use of this bed mobility device. The ADOC said staff in the home had been using the terms for different devices interchangeably. The ADOC said the home was in the process of reviewing and revising the policies related to Personal Assistive Services Devices (PASDs) including devices for bed mobility. The ADOC said the process in the home at the time of the inspection was that the Physiotherapist (PT) had been doing the assessments and the home was in the process of implementing a nursing assessment as part of the assessment and they were waiting for the corporate office to implement.

When asked specific questions about this resident, the ADOC said they were familiar with this resident and had been involved in assessing the resident's bed mobility and the changes made to their special interventions. The ADOC acknowledged that the device that was in place had not been assessed by the interdisciplinary team or included in the plan of care when it was added as an intervention after the resident was admitted to the home. The ADOC said interdisciplinary assessments had been completed at specific times. The ADOC said they thought the family for this resident wanted a specific type of device to be assessed, but that device was not an intervention available to be used in the home for specific reasons. The ADOC acknowledged that this resident had a specific type of specialized mattress in place and this had not been assessed and was not included in the plan of care.

The clinical record for this resident showed a specific device had been added to the resident's bed system on a specific date. The record did not include a documented assessment for the use of a specific type of assistive device until five months after it had been implemented. The plan of care for this resident since admission to the home did not consistently include the special devices in place for bed mobility.

During an interview with a registered nursing staff member they said this resident had a specific device in place for a specific reason and there had been changes made to

the interventions. They said the resident required a specific type of assistance from staff with bed mobility.

During an interview the Physiotherapist (PT) said they had started in the home in August 2019 and soon after they had started they were asked to assess specific residents for their bed mobility and use of PASDs. The said they documented these assessments in the progress notes. They said that based on these assessments they made recommendations and then the nursing team was responsible for updating the plan of care. The PT said they had assessed this specific resident and had made specific recommendations.

During an interview the Executive Director (ED) said the management had identified a risk with the use of a specific type of device in the home and had taken action to reduce the risk for residents. The ED said the home was working to review and revise the polices related to PASD and the use of these devices. The ED said the current policy in the home did not provide direction for staff related to the assessments of these specialized devices, apart from those considered to be a restraint. The ED said it was the expectation in the home that specialized interventions would be assessed by the interdisciplinary team and included in the plan of care.

B) Inspector #630 observed that another identified resident had specific interventions in place related to bed mobility.

During an interview this resident stated they had a specific concern about their bed system.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During an interview with staff they said this resident required a specific type of assistance from staff with bed mobility and specific specialized devices in place. They said they were not sure which devices were in place at the time of the inspection.

During an interview the ADOC said they were familiar with this resident. The ADOC said the plan of care for resident did not identify the specialized type of mattress that was used by the resident. The ADOC said there had been changes made to the resident's bed system and acknowledged prior to the change it was unclear what assessment had been completed by the interdisciplinary team related to the devices in place.

C) During an interview with another identified resident they said they had a change in their mattress and the devices on their bed. The resident said they did not think they had a special mattress and they had a specific device in place on their bed. The resident said they wanted specific changes made to the devices on their bed and had told that to someone in the home. The resident and Inspector #630 observed their bed system and the resident acknowledged that there was a specific type of mattress on the bed and the resident said they thought everyone had that type in the home.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During separate interviews with a registered nursing staff member, the PT and the ADOC they said they were familiar with this resident and they required a specific type of assistance from staff with bed mobility. They said specific changes had been made to this resident's bed system and assessments for specific things had not been done.

D) Inspector #630 observed that another specific resident's bed had a specific device in place.

The clinical record for this resident did not include an assessment for the special intervention that was observed to be in place at the time of the inspection. The clinical record also showed that the change to a specific device related to bed mobility had not been assessed for a specific time frame.

During an interview the ADOC said they were familiar with this resident and they used a specific type of device to assist with bed mobility. The ADOC was unsure how long the device had been in use and they were unable to find an assessment of

the use of this device.

During an interview the PT said they had been involved in assessing this resident on a specific date for the use of a specific device. The PT said they had no prior involvement in assessing this resident for the use of this intervention.

E) Inspector #630 observed another resident's bed system and identified it had a specific type of specialized mattress.

The clinical record for this resident did not include an assessment of this specialized mattress or include it as an intervention in the plan of care.

During an interview the ADOC said this resident had a specific type of specialized mattress on their bed. The ADOC acknowledged this was not included in the plan of care and the resident had not been assessed for this specialized intervention and said they did not know if there was a specific purpose for the mattress for this resident.

Upon request, the ED provided the manufacture's specification for this specialized mattress that was used in the home. The document indicated the mattresses had a specific name and identified the special purposes for this mattress. The ED said they were aware that home did have specialized mattresses that were in use. The ED said these had been in place prior to them starting in their role and they were looking into why they were purchase and the intended purpose. The ED said the priority in the home had been addressing and mitigating the potential risk related to a specific type of device and they were working to make further changes and improvements related to the use of PASDs in the home.

Based on observations, interviews and record review the specialized bed system interventions that were in place for residents had not been consistently assessed by the interdisciplinary team in the home and were not consistently included in the plan of care. The homes' written polices and procedures for assessing and implementing specialized interventions was in the process of being reviewed and revised, and at the time of the inspection it did not provide clear direction to staff regarding the process for the interdisciplinary assessments and care planning. [s. 26. (3) 18.]

The severity of this issue was determined to be a level two as there was minimal risk.

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

The scope of the issue was a level three as it was widespread as it affected 5 out 5 residents in the sample. The home had a level 3 history as a there was previous non-compliance related to the same sub-section of the legislation that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued June 29, 2017 (2017_605213_0007). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 15, 2020(A1)

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

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 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:

Ontario

Ministry of Long-Term Care

Ministère 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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 14th day of July, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMIE GIBBS-WARD (630) - (A2)

Ontario

Ministry of Long-Term Care

Ministère 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 Service Area Office