Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2016	2015_195166_0027	032898-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

CAROLINE TOMPKINS (166), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 30, December 1 ,2, 3, 4, 7, 8, 2015.

Complaint logs# 017029-15, 019827-15, 020317-15, 024960-15, 025760-15, 033110-15 and Critical Incident log#,025128-15, 09326-15, 021713-15 and 018834-15 were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, President of the Residents' Council, President of the Family Council, Director of Care(DOC), Administrator, Regional Director for Extendicare, interim Environmental Manager, Maintenance personnel, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Housekeeping, Office Manager, Physio-Therapist, Behaviourial Support Team member(BSO), Resident Assessment Instrument Coordinator(RAI), Nutritional Manager, Activation Aide and Recreation Manager.
During the course of this inspection, the inspectors observed staff to resident interactions, toured resident home and common areas, observed a dining service and medication administration.
The inspectors reviewed clinical records, documentation related to the licensee's internal investigations, complaint procedures: reviewed the licensee's policies related to the licensee's falls prevention and management program, prevention of abuse and neglect, mandatory reporting, staff training records,and staffing schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

- **8 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to falls.

Related to log #020317-15:

Review of six months of progress notes for resident #025 indicated:

Resident #025 has been identified as part of the falling star program and falls prevention program".

During the six month period resident #025 was found on the floor on four identified dates and one of the falls resulted in resident #025 being transferred to the hospital for an

injury that required treatment.

Review of the plan of care for resident#025 related to falls indicated the resident was at high risk for falls related to lack of insight for own safety, wanders independently and has a history of falls. The care plan interventions included a number of safety measures.

During three days of observation, the resident was observed not using the safety equipment outlined in the resident’s care plan.

Interview of Staff#128 indicated resident #025 was a moderate risk for falls and independently wanders the unit without the use of mobility aides. The staff indicated the resident refuses to use one of the care planned safety equipment.

Interview of the Physiotherapist (PT) indicated the last post fall assessment completed for resident #025 was approximately eight months ago and the PT was not aware that resident #025 had sustained 4 more falls since that time. The PT also indicated a referral related to falls had not been received for resident #025.

Interview of Staff#100 indicated that one of the safety features identified in resident #025’s care plan was being used for responsive behaviours not falls prevention. [6. (1)(c)](111)

Related to log # 018834-15:

The licensee failed to ensure that resident #047’s care set out in the plan that had not been effective, shall ensure that different approaches are considered in the revision of the plan of care.

A critical incident report (CIR) was received and indicated resident #047 had a fall that caused an injury that resulted in resident #047 being sent to the hospital. The injury resulted in a significant change in the resident's health status.

Review of resident #047’s progress notes for an identified five month period prior to the critical incident indicated the resident was found on the floor on four occasions, there was no noted injury following the first fall, minor injury on the second and third fall, and on the fourth fall the resident was transferred to the hospital and required treatment that resulted in a significant change in the resident’s condition.

The resident returned to the home and was assessed by PT fourteen days later who recommended a change in the resident's mobility and transfer devices.

On an identified date, approximately one month after the resident returned from the hospital the falls prevention lead indicated “the resident is a high risk for falls related to multiple falls”.

A bowel/bladder assessment was initiated to determine any relation between falls and continence issues and assessment indicated the resident would benefit from a continence program as part of falls prevention program.

On identified dates over another five month period, resident #047 was found on the floor with no injury on three occasions and was found on the floor with an injury on two occasions. As a result of the last fall the resident was transferred to hospital for further evaluation.

On identified dates over the same five month period, resident #047’s was found attempting to stand without assistance on five occasions and removed safety device on one occasion. The POA was notified "will ensure resident has an identified safety device" and scheduled a care conference.

On an identified date a care conference was held with POA and Physician after the eighth fall, indicated “concerns re: falls”. Recommended a BSO assessment and for the POA to consider further interventions.

Four days after the care conference, the falls prevention lead indicated, "continue with current interventions and ongoing assessments”. Documentation indicated discussions held family and suggestions that have been made to reduce risk of falls.

Review of BSO referral on an identified date indicated recurrent falls, protective devices in place, encourage out of room. A behaviour assessment tool was started for two days.

Review of resident #047 care plan that was in place at time of the falls indicated the resident required two staff assistance with all transfers, and used a mobility aid.
The resident was at risk for falls due to unsteady gait, forgets to use walker due to cognitive impairment, history of falls resulting in an injury that caused a significant change in condition and has fallen on six occasions since admission.

The care plan interventions included a number of safety measures, however, when the resident was reassessed and the plan of care revised, different approaches were not considered when the plan was not effective, as the resident continue to sustain ongoing falls. [s.6. 11) (b)](111)

Related to log # 019827-15:

Review of the progress notes for resident #053 indicated:
On an identified date, resident #053, was found on the floor,twice on the same date. The resident was assessed, no injuries were sustained and the resident denied any discomfort.

Resident #053 was placed on every 15 minute checks, the care plan was updated, to include use of alarms floor mat, 15 minutes checks, and laboratory tests.

Later on the same identified date, resident #053 was observed crying and complaining of pain. The physician was called and resident was sent to hospital for an assessment and it was determined the resident had sustained an injury.

Approximately a month post initial injury, resident #053 had another fall. There was no documented assessment to indicate whether the resident had any pain or injury at the time of the fall.

Later the same day, resident #053 was unable to weight bear and complaining of pain. The resident was transferred to hospital for assessment. The injury resulted in a significant change in resident #053’s health status.

Different approaches were not considered in the revision of the plan when it was demonstrated to be ineffective.[s.6.(11)(b)](111)

Related to log # 019827-15:

Review of the progress notes for resident #054 indicated , that within a two month time period , resident #054 had twelve documented falls. The resident did not sustain any injuries related to the falls.

OT assessed and spoke to resident ‘s POA "to consider other options to reduce falls risk". The OT advised the Registered staff member to add other falls prevention

interventions to the plan of care.

After the twelfth fall a post fall huddle was held and the staff noted the resident "becomes most restless when has to use the washroom, suggest to toilet resident 30 minutes post meal and post nourishment".

A second post fall huddle was held the same day, indicating resident is toileted post meals and snack and as needed, when staff see resident getting restless, they would approach the resident to take for a short walk, chair alarm with blue pad initiated to staff could respond faster to the alarm and resident educated on importance of calling for help when needed:" POA was educated on same.

Review of the care plan for resident #054 indicated at risk for falls related to unaware of personal safety as evidenced by multiple falls and unsteady gait.

Interventions included falling star program, high low bed in lowest position at all times, floor mats at open side of bed, wheelchair and bed alarms, never leave on toilet unattended, monitor for restless/repetitive movements when in wheelchair and offer toileting.

Although interventions were considered, when they were noted to be ineffective, other interventions were not considered in the revision of the plan of care as the resident continued to fall.

There was no indication other multidisciplinary staff were involved in the revision of the plan related to falls until the physician and OT was notified (after the seventh fall and only reported the recent three falls that had occurred).[6.(11)(b)](111)

Resident #014 related to falls

The resident has been observed throughout the course of the inspection and he/she has an unsteady gait and ambulates with a mobility device.

Review of the clinical health records indicates the resident had two falls
in a six month period. The fall assessment was completed and identified the resident as being at high risk for falls.

The care plan also identifies the resident as high risk for falls and that the resident is on

the falling star program to assist in reducing falls.

Interview with Staff 112 who explained the resident mobilizes independently with a mobility aid and is not known to be at high risk for falls.

Interview with Staff#115 and Staff#113 who also both explained the resident mobilizes around the unit with a mobility aide and they were unaware of the resident being at a high risk for falls.

During an interview with the Staff#102, indicated the resident has been assessed and identified as high risk for falls and is supposed to have the falling star logo on their mobility device as well as in the bedroom to alert staff of risk for falls.

The resident was observed during the course of the inspection and the resident's mobility device did not have a falling star logo neither was there are falling star logo in the resident's bedroom.[s.6.(1)c](111)

The licensee has failed to ensure that the SDM, if any, and the designate of the resident, had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to log # 020317-15:

Review of the progress notes for resident #025, indicated:

On an identified date, the resident "was agitated and aggressive" during care.

Seven days later, the resident was experiencing some swelling in a specified site. Staff notified the physician. New orders received for an analgesic to be administered every 4 hours, when required for pain for 2 weeks.

The site of the swelling remained unchanged for 3 days and the resident "slept poorly through the night". The resident was given analgesic for pain and swelling with effect.

The physician was faxed regarding the injury and ordered a mobile x-ray.
Three days after the order for an x-ray, the physician ordered the x-ray canceled.

There was no indication the family was notified of the change in condition related to the resident's injury or an order for an x-ray, or the decision to not have the x-ray.[s.6.(5)] (111)

Related to log # 021713-15:

A critical incident report was received for a fall resulting in injury and which the resident was taken to hospital.

The CIR indicated, resident #041 fell from an assistive device. At the time of the incident the resident was assessed and had sustained a bruise and abrasion.

One day post incident the resident was sent to hospital for further assessment and treatment. The resident had sustained other injuries that resulted in a significant change in resident #041's health status.

Review of care plan for resident #041 indicated the resident is a high risk for falls. Interventions included: Under bathing, two person physical assist when bathing and certain restrictions regarding staff who may or may not provide care to the resident as per SDM request.

Review of the home's investigation and interview of the Administrator indicated:

Contrary to resident #041's plan of care, Staff #131, transferred the resident without the assistance of a second staff member and was not to be providing assistance with bathing as per restrictions.[6.(7)] [s. 6. (1) (c)](111)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

Related to Log -019326-15

The licensee has failed to ensure that staff use safe transferring and techniques when assisting residents.

On an identified date a Critical Incident(CIR) was received reporting and injury to a resident that required the resident to be transferred to a hospital for further assessment.

Review of the CIR indicated that on an identified date, resident #046 reported being toileted by a staff member after the resident denied requiring toileting or assistance. The resident told the staff member, no help was required and that the resident was able to transfer independently.

Documentation indicates the staff member did not listen to the resident and proceeded with the transfer.

When the resident was transferred back into bed, the resident sustained an injury that required transfer and treatment at the hospital.

Review of resident #046's plan of care prior to injury, interview with Staff #133, #124, #109 and interview with resident #046 indicated that the resident was able to transfer independently without assistance.

Resident #046 now requires extensive assistance from 1 staff to sit up in bed and to transfer. [s. 36.](166)

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 ensure that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. 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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incident of falls and the risk of injury.

Related to logs # 019827-15, 020317-15 & 021713-15, 018834-15:

Review of the home's "Falls" policy (RESI-09-02-01) revised November 2011 indicated:
-each home will establish a Falls Prevention and Management Committee to oversee the Falls Prevention and Management Program, analyze fall incident data (using a Post Fall Analysis form), make recommendations related to ongoing training for employees, and provide annual report of the fall prevalence and incidence.

-interventions to be included in the preventative strategies in the care plan based on the individualized resident assessment included 'referral to physio therapy',
-each home will implement a 'flagging system' to clearly identify to all staff which residents are at high risk for falls.

Review of the Terms of Reference for Falls Prevention and Restraints Committee indicated: the frequency of the meetings was to occur monthly and membership included the DOC, RN, RPN, RAI Coordinator, PSW from each shift/each unit, and the Clinical Coordinator.

Review of the "Fall's and Restraint Committee Meeting" minutes for 2015 indicated there was only evidence of one documented meeting (September 17, 2015) which was attended by Staff#102, the RAI Coordinator, 2 PSWs, 1 RN and a representative from the corporate office. There was no indication that the Administrator, DOC or PT attended.

The minutes indicated the home had a high number of falls.
The minutes also indicated the home currently has a 'falling star program' and "looking into red sock program" with a trial of red socks on an individual basis.

Interview of Staff#102 (Falls Prevention Committee Lead) indicated:

-the program was initiated in early January 2015 and was to include the Restraints/Restorative Care.
-tracks all the falls in the home by checking the computer daily for any falls that have occurred and creates a falls audit tool, checks that all the required information has been completed (i.e. post fall huddle, post fall assessment, internal incident report, care plan updated, and introduce any interventions to prevent falls).
-the "Falling Star Program" includes: falling star logo that is placed on resident head board and any mobility aides, updating care plans, introduction of interventions to reduce or mitigate falls (i.e. falls mat, side rails, bed alarms, restraint, etc.).
-there is a Falls Prevention Committee which includes PT and they are to meet every two months (but has not been occurring regularly).
-is still trying to ensure that fall's prevention policies/forms are consistently implemented by staff and still attempting to update a new program with falls risk
-the Fall's Prevention Committee's has a 'terms of reference'
-was only able to locate meeting minutes for September 17, 2015.
-has never received any Post Fall Analysis Forms.

Interview of the PT(physiotherapist) indicated:
- in the home one day/week.
- a PTA (physiotherapist assistant) is in the home 5 days/week.
- the home is to send a referral to PT if a resident has fallen to assess and provide recommendations post fall.
-any referrals received would document the assessment and recommendations for the resident in the resident's progress notes.
-also reviews falls at the end of each month to analyze for trends but did not have any documentation of this analysis.
-is a member of the Fall Prevention Committee but could not recall the last time when attended a meeting in 2015.
-indicated additional members included the Administrator, DOC,and Staff#102.

The PT indicated was not aware that resident #025 had sustained 4 more falls since the last assessment and did not receive any referrals for the falls. The PT when asked whether she noted the falls of resident #025 in her monthly review of falls, stated she “doesn't always have time to check on all the falls” and stated she had “not reviewed the monthly falls for the last couple of months”.

Interview of the Administrator indicated she had not attended any Falls Prevention Committee meetings, and stated the "red socks' was “implemented some time during this year” but was not able to recall when or by whom.
The Administrator also stated that the home “does have a ‘falling star program’ that is supposed to be implemented in the home which includes placing the star logo on resident's mobility aides and at bedside”.

Review of the Falls Audit Tool indicated resident #025, had a quarter of the falls recorded during the same time period the falls occurred. The plan of care for resident #025 related to risk for falls did not indicate under interventions to complete a referral to PT.

There was no ‘Post Fall Analysis’ or investigation into the incident where resident #025 sustained an injury on an identified date to determine the cause of injury. There was no indication that PT was to be involved in the Falls Prevention committee.

During this inspection, residents #014, #025, #041 #047, ##053, # 054 were identified as frequently falling. Residents #025, #041 #047, ##053, #054, all sustained injuries due

to falling and required further treatment.

The Falls Prevention was only partially developed and/or implemented increasing further risks to residents. [s. 48.(1) 1.](111)

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 falls prevention and management program is reviewed, revised and implemented to reduce the incidence of falls and risk of injury to all residents that have been identified as moderate to high risk of falling, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident had been assessed using a post fall assessment, using a clinically appropriate assessment instrument that is specifically designed for falls.

Related to log# 020317-15:

Review of the progress notes for resident #025 during a six month time period indicated:

Resident #025 had fallen four times within that time period, the resident sustained an injury that required further treatment after one incident of a fall.

Interview of the RAI Coordinator and DOC indicated all the Post Fall Assessments prior to November 1, 2015 were completed on paper but is now to be completed electronically post fall on a computer program.

Review of electronic and paper health records for resident #025 indicated a paper "Post Fall Assessment" was completed for two of the falls but no documented post fall assessments were completed for the other two falls.

Related to log # 019827-15:

On an identified date, resident #053, twice, was found on the floor. The resident denied any discomfort.

Later on the same identified date, resident #053 was observed crying and complaining of pain. The physician was called and resident was sent to hospital for an assessment and it was determined the resident had sustained an injury.

Approximately a month post initial injury, resident #053 was observed falling to the floor. There was no documented assessment to indicate whether the resident had any pain or injury at the time of the fall.

Later that same date, resident #053 was unable to weight bear and complaining of pain. The resident was transferred to hospital for assessment. The injury resulted in a significant change in resident #053's health status.

Review of post fall assessments indicated there were only two completed. The post fall assessment completed had no indication of time of fall. A second post fall assessment did not indicate the resident had sustained two falls within an hour.

There was also no indication in progress notes of post fall assessments to indicate whether the resident had any injury or pain post falls.

Related to log # 018834-15:

Review of the progress notes for resident #047 indicated the resident sustained twelve falls in six months. Two incidents that required the resident to be transferred to the

hospital for further assessment and treatment.

Interview of the RAI Coordinator indicated a paper "post fall assessment tool" is to be used whenever a resident has sustained a fall.

Review of the post falls assessments indicated of the documented falls only four post fall assessments were completed. [s. 49. (2)](111)

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Logs #024960-15, #025128-15, #025760-15

The licensee failed to ensure that the responsive behaviours for resident #049 were reassessed and different strategies initiated when the current interventions were no longer effective.

In interviews, Behavioural Support of Ontario (BSO)Staff #100 indicated that the BSO team was involved with resident #049 and had put in place multiple strategies and interventions, including the use of a Behaviourial Assessment Tool (B.A.T), to prevent aggression by resident #049 towards staff and residents.

A review of resident #049's current Behavioural Assessment Tool (BAT) indicated that resident #049 displayed verbal and physically aggressive behaviour:

Interventions for these behaviours includes: separate resident #49 from other residents; try and find out what triggered the behaviour; explain it is wrong; remove all residents who are at risk; firmly speak to resident #049.

A review of the clinical records indicated that resident #049 had been assessed by community support services and recommendation were put in place.

A review of resident #049's plan of care indicated multiple triggers and interventions.

A review of the clinical record for resident #049 indicated twenty documented incidents of physical and verbal responsive behaviours, directed towards other residents demonstrated by resident #049:

Therefore, due to the number of responsive behaviour incidents demonstrated by resident #049, the licensee failed to reassess resident #049's responsive behaviours and develop additional strategies when the existing strategies were not effective.[s. 53. (4) (b)].(571)

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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including reassessments and interventions and that the resident's responses to interventions are documented., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of : an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital.

Related to log # 018834-15:

A critical incident report (CIR) was received reporting a fall that caused an injury which the resident was taken to hospital and which resulted in significant change in the resident's health status.

Review of the CIR indicated that resident #047 was found on the floor was transferred to hospital for further assessment.

Interview of ADOC (who completed the CIR) indicated she did not contact the Director on the date of the incident as she only became aware three days post incident of the significant change in the resident's status.

Review of the clinical record for resident #047 indicated a significant change in health status of resident #047 the day after the fall.

Review of after hours contact indicated no after hours call was received related to this incident. [s. 107. (3)](111)

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 Director is informed of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): (3.1), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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. Related to log 033110-15

A complaint was received alleging that some of the registered staff had made several transcription errors of Physician's medication orders.

Interview with the Director of Care, Staff #113 and Staff #114 indicated the Registered staff are required to follow the medication policies as provided by LMP Advantage Care Pharmacy Services.

The medication policy #8-3, "Transcribing Physician's orders to a MAR sheet" directs registered staff to:

Ensure that all physicians"s orders are transcribed accurately and completely to the patient record on the MAR

Discontinuing Orders-paper based MAR system:
a) place an X through the entire box containing the medication order
b)Draw a vertical line after the last dose
c) write D/C, date and initial after the last dose

Adding New Orders
a) Include the name and the strength of the medication, dosage, route if other than oral,full directions, duration of treatment if specified and date of order.b) Add the time the medication is to be administered
c) If using a paper based MAR system , draw a vertical line to indicate the start of the first dose.

Interview with the Administrator, the Director of Care, review of clinical documentation and review of the licensee's investigation related to the transcribing of physician's orders as per the licensee's medication policy by Staff#126 and Staff#130 indicated:

On a specified date, resident #051, who was receiving an analgesic began to experience difficulty with mobility, could not weight bear became confused and shaky.
Staff #130 notified the physician, who ordered the analgesic to be discontinued and to monitor the resident.

Staff #130, discontinued the analgesic but did not transcribe the order in resident #051's medication records as per the licensee's medication policy #8-3, Transcribing Physician's orders to a MAR sheet.

On a second identified date, Staff #126 assessed resident #051, who now indicated experiencing pain.
Staff #126 notified the physician, who ordered that the analgesic be restarted and the resident to be monitored.
Staff #126 administered the analgesic to the resident as per the physician's order, but failed to transcribed the renewed order in resident #051's medication record as per the licensee's medication policy #8-3, Transcribing Physician's orders to a MAR sheet. [s. 8. (1) (b)].(166)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

Interview of a family member for resident #026 during stage 1 of the RQI indicated the family member had concerns regarding charges from a service provider for repairs to the resident's mobility and positioning device and had expressed the concern to the home.

Review of the home's "Complaints" policy (09-04-06) revised June 2010 indicated "the home will respond to complaints whether they are written or verbal in a timely manner. Verbal complaints that can be resolved within 24 hours do not require a written investigation report, however, if the verbal complaint cannot be resolved within 24 hrs, a written record of the complaint as well as the investigation and outcome will be retrained by the home. On page 3 of 9, when a verbal complaint is received, the person receiving the complaint will obtain as many details as possible regarding the complaint, an investigation will be initiated immediately, the department manager will verbally respond to the person making the complaint the outcome/resolution, each contact with the resident or author of the complaint will be recorded on the Contact Log by the person making the complaint.

Interview of the office manager indicated that charges for wheelchair repairs are submitted directly to the families from the service provider and do not come out of the accommodation or trust accounts.

Interview of Staff# 111 indicated that if there is a concern regarding a resident's mobility aid the registered nursing staff notify the family, and then fill out/ fax a service request form to the service provider to have the device repaired. The Staff indicated the service provider is responsible for contacting the family regarding the repair to get consent for any charges.

Review of the service provider's request forms binder indicated that on the top of the binder, was a note taped regarding resident #26, directing the service provider to "please call family prior to repairs. There were five service request forms completed all related to repairs required for the resident's mobility and positioning device.

Interview of Staff #100 indicated awareness of the family of resident #026 having concerns regarding charges and posted the note on the service provider's binder as the family "was upset". The Staff#100 indicated she reported the complaint to the charge nurse.

Interview of the Administrator and DOC indicated no awareness of verbal complaints received from the family of Resident #026 related to charges by a service provider. [s. 101. (1) 1.](111)

Issued on this 4th day of February, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLINE TOMPKINS (166), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2015_195166_0027
Log No. / Registre no:	032898-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 22, 2016
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Port Perry Place 15941 Simcoe Street, Port Perry, ON, L9L-1N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to ensure the following:
1. Review and revise the plan of care for Resident #014 & #025, and any other residents determined to be at moderate to high risks for falls, to ensure the plan sets out clear directions to staff and others who provide direct care to the residents.

2. Review the plan of care for Resident #046, and any other residents determined to be at moderate to high risk for falls, to ensure the plan of care is provided to those residents.

3. Re- train all staff in the homes Falls Prevention Program using Resident #047, Resident #053 & Resident #54(all deceased) as case studies to determine strategies that could be used to prevent or mitigate further falls/injuries from occurring for current residents determined to be moderate to high risk for falls.

4. Develop a process to ensure that all residents at moderate to high risk for falls or who have fallen are assessed using a clinically appropriate assessment instrument designed for this purpose and are monitored accordingly and ensure that appropriate strategies are developed and implemented in the plan of care.

This plan is to be submitted to Caroline Tompkins by February 5, 2016 via email to OttawaSAO.MOH@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to falls.

Related to log #020317-15:

Review of six months of progress notes for resident #025 indicated:

Resident #025 has been identified as part of the falling star program and falls prevention program".

During the six month period resident #025 was found on the floor on four identified dates and one of the falls resulted in resident #025 being transferred to

the hospital for an injury that required treatment.

Review of the plan of care for resident#025 related to falls indicated the resident was at high risk for falls related to lack of insight for own safety, wanders independently and has a history of falls. The care plan interventions included a number of safety measures.

During three days of observation, the resident was observed not using the safety equipment outlined in the resident's care plan.

Interview of Staff#128 indicated resident #025 was a moderate risk for falls and independently wanders the unit without the use of mobility aides. The staff indicated the resident refuses to use one of the care planned safety equipment.

Interview of the Physiotherapist (PT) indicated the last post fall assessment completed for resident #025 was approximately eight months ago and the PT was not aware that resident #025 had sustained 4 more falls since that time. The PT also indicated a referral related to falls had not been received for resident #025.

Interview of Staff#100 indicated that one of the safety features identified in resident #025's care plan was being used for responsive behaviours not falls prevention. [6. (1) (c)](111)

Related to log # 018834-15:

The licensee failed to ensure that resident #047's care set out in the plan that had not been effective, shall ensure that different approaches are considered in the revision of the plan of care.

A critical incident report (CIR) was received and indicated resident #047 had a fall that caused an injury that resulted in resident #047 being sent to the hospital. The injury resulted in a significant change in the resident's health status.

Review of resident #047's progress notes for an identified five month period prior to the critical incident indicated the resident was found on the floor on four occasions, there was no noted injury following the first fall, minor injury on the second and third fall, and on the fourth fall the resident was transferred to the hospital and required treatment that resulted in a significant change in the

resident's condition.

The resident returned to the home and was assessed by PT fourteen days later who recommended a change in the resident's mobility and transfer devices.

On an identified date, approximately one month after the resident returned from the hospital the falls prevention lead indicated "the resident is a high risk for falls related to multiple falls".

A bowel/bladder assessment was initiated to determine any relation between falls and continence issues and assessment indicated the resident would benefit from a continence program as part of falls prevention program.

On identified dates over another five month period, resident #047 was found on the floor with no injury on three occasions and was found on the floor with an injury on two occasions. As a result of the last fall the resident was transferred to hospital for further evaluation.

On identified dates over the same five month period, resident #047's was found attempting to stand without assistance on five occasions and removed safety device on one occasion. The POA was notified "will ensure resident has an identified safety device" and scheduled a care conference.

On an identified date a care conference was held with POA and Physician after the eighth fall, indicated "concerns re: falls". Recommended a BSO assessment and for the POA to consider further interventions.

Four days after the care conference, the falls prevention lead indicated, "continue with current interventions and ongoing assessments". Documentation indicated discussions held family and suggestions that have been made to reduce risk of falls.

Review of BSO referral on an identified date indicated recurrent falls, protective devices in place, encourage out of room. A behaviour assessment tool was started for two days.

Review of resident #047 care plan that was in place at time of the falls indicated the resident required two staff assistance with all transfers, and used a mobility aid.

The resident was at risk for falls due to unsteady gait, forgets to use walker due to cognitive impairment, history of falls resulting in an injury that caused a significant change in condition and has fallen on six occasions since admission.

The care plan interventions included a number of safety measures, however, when the resident was reassessed and the plan of care revised, different approaches were not considered when the plan was not effective, as the resident continue to sustain ongoing falls. [s.6. 11) (b)](111)

Related to log # 019827-15:

Review of the progress notes for resident #053 indicated:
On an identified date, resident #053, was found on the floor,twice on the same date. The resident was assessed, no injuries were sustained and the resident denied any discomfort.

Resident #053 was placed on every 15 minute checks, the care plan was updated, to include use of alarms floor mat, 15 minutes checks, and laboratory tests.

Later on the same identified date, resident #053 was observed crying and complaining of pain. The physician was called and resident was sent to hospital for an assessment and it was determined the resident had sustained an injury.

Approximately a month post initial injury, resident #053 had another fall. There was no documented assessment to indicate whether the resident had any pain or injury at the time of the fall.

Later the same day, resident #053 was unable to weight bear and complaining of pain. The resident was transferred to hospital for assessment. The injury resulted in a significant change in resident #053's health status.

Different approaches were not considered in the revision of the plan when it was demonstrated to be ineffective.[s.6.(11)(b)](111)

Related to log # 019827-15:

Review of the progress notes for resident #054 indicated , that within a two month time period , resident #054 had twelve documented falls. The resident did

not sustain any injuries related to the falls.

OT assessed and spoke to resident ‘s POA "to consider other options to reduce falls risk". The OT advised the Registered staff member to add other falls prevention interventions to the plan of care.

After the twelfth fall a post fall huddle was held and the staff noted the resident "becomes most restless when has to use the washroom, suggest to toilet resident 30 minutes post meal and post nourishment".

A second post fall huddle was held the same day, indicating resident is toileted post meals and snack and as needed, when staff see resident getting restless, they would approach the resident to take for a short walk, chair alarm with blue pad initiated to staff could respond faster to the alarm and resident educated on importance of calling for help when needed:" POA was educated on same.

Review of the care plan for resident #054 indicated at risk for falls related to unaware of personal safety as evidenced by multiple falls and unsteady gait.

Interventions included falling star program, high low bed in lowest position at all times, floor mats at open side of bed, wheelchair and bed alarms, never leave on toilet unattended, monitor for restless/repetitive movements when in wheelchair and offer toileting.

Although interventions were considered, when they were noted to be ineffective, other interventions were not considered in the revision of the plan of care as the resident continued to fall.

There was no indication other multidisciplinary staff were involved in the revision of the plan related to falls until the physician and OT was notified (after the seventh fall and only reported the recent three falls that had occurred).[6.(11)(b)] (111)

Resident #014 related to falls

The resident has been observed throughout the course of the inspection and he/she has an unsteady gait and ambulates with a mobility device.

Review of the clinical health records indicates the resident had two falls

in a six month period. The fall assessment was completed and identified the resident as being at high risk for falls.

The care plan also identifies the resident as high risk for falls and that the resident is on the falling star program to assist in reducing falls.

Interview with Staff 112 who explained the resident mobilizes independently with a mobility aid and is not known to be at high risk for falls.

Interview with Staff#115 and Staff#113 who also both explained the resident mobilizes around the unit with a mobility aide and they were unaware of the resident being at a high risk for falls.

During an interview with the Staff#102, indicated the resident has been assessed and identified as high risk for falls and is supposed to have the falling star logo on their mobility device as well as in the bedroom to alert staff of risk for falls.

The resident was observed during the course of the inspection and the resident's mobility device did not have a falling star logo neither was there are falling star logo in the resident's bedroom.[s.6.(1)c](111)

The licensee has failed to ensure that the SDM, if any, and the designate of the resident, had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to log # 020317-15:

Review of the progress notes for resident #025, indicated:

On an identified date, the resident "was agitated and aggressive" during care.

Seven days later, the resident was experiencing some swelling in a specified site. Staff notified the physician. New orders received for an analgesic to be administered every 4 hours, when required for pain for 2 weeks.

The site of the swelling remained unchanged for 3 days and the resident "slept poorly through the night". The resident was given analgesic for pain and swelling

with effect.

The physician was faxed regarding the injury and ordered a mobile x-ray. Three days after the order for an x-ray, the physician ordered the x-ray canceled.

There was no indication the family was notified of the change in condition related to the resident's injury or an order for an x-ray, or the decision to not have the x-ray.[s.6.(5)](111)

Related to log # 021713-15:

A critical incident report was received for a fall resulting in injury and which the resident was taken to hospital.

The CIR indicated, resident #041 fell from an assistive device. At the time of the incident the resident was assessed and had sustained a bruise and abrasion.

One day post incident the resident was sent to hospital for further assessment and treatment. The resident had sustained other injuries that resulted in a significant change in resident #041's health status.

Review of care plan for resident #041 indicated the resident is a high risk for falls.
Interventions included: Under bathing, two person physical assist when bathing and certain restrictions regarding staff who may or may not provide care to the resident as per SDM request.

Review of the home's investigation and interview of the Administrator indicated:

Contrary to resident #041's plan of care, Staff #131, transferred the resident without the assistance of a second staff member and was not to be providing assistance with bathing as per restrictions.[6.(7)] [s. 6. (1) (c)](111)

(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

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

Issued on this 22nd day of January, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROLINE TOMPKINS

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