Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2019	2019_679638_0002	020484-18, 023445-18, 023645-18, 024700-18, 025091-18, 025160-18, 025482-18, 031360-18, 031408-18	Complaint

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642), CHAD CAMPS (609), STEPHANIE DONI (681)

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 7 - 11 and 14 - 18, 2019.

The following intakes were inspected during this Complaint inspection;

-One log was a complaint submitted to the Director which was related to improper medication administration and management;
-One log was a complaint submitted to the Director which was related to allegations of improper care related to skin and wound care and medication management;
-Two logs were complaints submitted to the Director which were related to resident specific responsive behaviours, sexual abuse, medication administration, continence care and wrongful discharge;
-One log was a complaint submitted to the Director which was related to home temperatures, availability of cleaning supplies and staffing shortages;
-Two logs were complaints submitted to the Director which were related to various care concerns, Substitute Decision Maker (SDM) involvement, medication management and infection prevention and control practices;
-One log was a complaint submitted to the Director which was related to the home's management of responsive behaviours; and
-One log was a complaint submitted to the Director which was related to the home's maintenance services and mould.

A Follow Up inspection #2018_679638_0001 and a Critical Incident Systems inspection #2018_679638_0003, were conducted concurrently with this Complaint inspection.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 20 (1), identified in a concurrent inspection #2019_679638_0003 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Environmental Manager, Consulting Nutrition Manager, Culinary Manager, Resident and Family Services Coordinator (RFSC), Life Enrichment Coordinator (LEC), Staffing Coordinator, Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitians (RD), Dietary Aids (DA), Housekeeping Aids, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the organized program of personal support services for the home met the assessed needs of the residents.

A) A CIS report was submitted by the Long-Term Care Home to the Director which outlined that on a specific date resident #007 was found inappropriately touching resident #011.

Inspector #609 reviewed resident #007's health care records and identified a progress note created three days prior to the specific incident, which indicated that RN #124 called the resident's family and requested they take the resident out of the Long-Term Care Home for a period of time. In another progress note created the date the incident occurred, RN #138 had advised the resident's Substitute Decision Maker (SDM) that they needed to take the resident with them, out of the Long-Term Care Home, or they would call an external agency to have the resident removed.

During an interview with Inspector #609, RN #138 verified what they had told resident #007's family. The RN stated that the DOC told them that under no circumstances was the resident to return to the Long-Term Care Home until management had made a decision regarding resident #007. RN #138 stated that the family had taken the resident out of the Long-Term Care Home. The RN verified that, despite a call from resident #007's SDM one day after taking the resident out of the Long-Term Care Home, they were indicating that they had to return the resident to the Long-Term Care Home, they (the RN) refused to allow them to bring the resident back to the Long-Term Care Home.

The Long-Term Care Home's policy titled "Resident Rights, Care and Services – Nursing and Personal Support Services – Staffing Plan" indicated that the written staffing plan included a staffing mix that was consistent with residents' assessed care and safety needs that met the requirements set out in the Act and Regulation.

During an interview with Inspector #609, the DOC verified that RN #138 was given instructions to tell resident #007's SDM that if they did not remove the resident from the Long-Term Care Home, that they would send the resident to an external agency. The DOC outlined how the Long-Term Care Home was very short staffed those specific dates and there was no staff to provide a specific intervention resident #007 required to ensure the safety of other residents.

A review of the Long-Term Care Home's unfilled shift report for the specific dates the incident occurred and found that the Long-Term Care Home was short nine PSW shifts on one date and 10.5 PSW shifts on the second date.

B) A CIS report was submitted by the Long-Term Care Home to the Director on a specific date, which outlined how at a specific time resident #007 was found inappropriately touching resident #012.

Inspector #609 reviewed resident #007's health care records and found in their plan of care, the resident required two specific interventions implemented, activated at all times and were to be provided a specific intervention when they were out of their room. The Inspector identified a progress note on the date of the incident which stated that PSW #142 did not activate the resident's specific intervention and allowed the resident to leave their room without implementing the specific intervention.

The Long-Term Care Home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of Care" last revised March 13, 2018, indicated that care was to be provided to the resident as specified in the plan of care.

During an interview with Inspector #609, PSW #142 verified that they did not review resident #007's plan of care prior to providing care. The PSW described they were short one RPN on a specific shift on the specific date of the incident, which resulted in no shift to shift report being conducted, which was the typical way that changes in residents' plans of care were communicated to the oncoming shift. They were also working short one PSW and did not have time to review the residents' plans of care before providing care.

A review of the Long-Term Care Home's unfilled PSW shifts found that the Home Area was short one RPN on one specific shift and one PSW on the other specific shift on the specific date of the incident.

C) Two complaints were submitted to the Director which outlined concerns that the family of resident #007 had to accommodate a specific intervention privately for the resident. The complaints alleged this was because the Long-Term Care Home lacked the staff necessary to provide the resident's specific intervention.

Inspector #609 reviewed a CIS report that was submitted by the Long-Term Care Home to the Director on a specific date, which indicated resident #007 was to have received a

specific intervention after the resident was found a second time, inappropriately touching resident #009.

A review of resident #007's health care records identified a progress note on the date of the incident, which indicated that the resident received a specific intervention after an incident of inappropriate touching.

During an interview with Inspector #609, the complainant described being told by staff that the family needed to provide the specific intervention to resident #007 or hire someone privately, because the Long-Term Care Home lacked the staffing.

Inspector #609 reviewed resident #007's health care records and found a progress note dated, three days after the incident, which outlined that the resident's SDM refused to take the resident out of the Long-Term Care Home on the specific dates, when staff first asked them, because of safety concerns.

During an interview with Inspector #609, the RFSC verified that they had provided resident #007's SDM with a list of private pay agencies to assist with the specific intervention because the Long-Term Care Home lacked the resources to provide.

During an interview with Inspector #609, the DOC verified that the family was advised by staff that someone was required to implement a specific intervention for resident #007 and suggested they hire an external agency to provide the care, because the Long-Term Care Home did not have the staff to provide the resident's required specific intervention.

D) During interviews with Inspector #609, the DOC and Co-DOC #1 could not produce documentation to support when or what staff provided resident #007's specific intervention. In another interview with the DOC, they verified that resident #007 was to receive the specific intervention on the specific date of the incident, after the second CIS report was submitted.

Inspector #609 reviewed resident #007's health care records and found in a progress note that stated staff should not be pulled from providing the resident's specific intervention.

During an interview with the Staffing Coordinator, a review of the Long-Term Care Home's unfilled PSW shifts for a three month period in 2018, and found that the Long-Term Care Home was short staffed PSWs, every day, within the three month review

period. The Inspector further reviewed the unfilled PSW shifts and found that there was;
-174 unfilled PSW shifts in the first month;
-202 unfilled PSW shifts in the second month; and
-153 unfilled PSW shifts in the third month.

In an interview with Inspector #609, the Staffing Coordinator acknowledged that there was currently no way for the Long-Term Care Home to track if the staff assigned to provide resident #007's specific intervention were pulled from providing resident #007's specific intervention.

A review of four CIS reports submitted by the Long-Term Care Home to the Director found that resident #007, did not have their required specific intervention implemented at the time of two of the four CIS reports. [s. 8. (1) (b)]

2. A complaint and a CIS report were submitted to the Director, on specific dates, which identified resident #006 as having an increase in specific responsive behaviours and the complainant was concerned for the safety of other residents and staff in the Long-Term Care Home.

Inspector #642 reviewed resident #006's progress notes and noted that the resident was returning to the Long-Term Care Home, on a specific date after an absence. The Inspector, further reviewed the progress notes and on a specific date three days prior to their expected return date, the Behavioural Support Ontario-Registered Practical Nurse (BSO-RPN), had identified that resident #006, had assessments completed and was recommended for a specific intervention that was to be implemented when the resident returned to the Long-Term Care Home.

On a specific date, one day after their readmission, Inspector #642 observed the Home Area, where resident #006 resided. The Inspector arrived on the unit at 0911 hours and identified that the resident was still in their room sleeping. At that time, the Inspector identified there was no specific intervention implemented outside or near resident #006's room.

Inspector #642 interviewed RPN #121 on the specific date of the observations. The RPN stated the specific intervention was not implemented for resident #006 and they were aware of the resident's responsive behaviours.

The Inspector interviewed RN #124 on the specific date of the observations. The RN

stated they did not have the specific intervention implemented because of staffing availability at that time. The RN stated they would have available staff at a different shift.

Inspector #642 interviewed the Staffing Coordinator, and after reviewing the staffing schedule for the specific date of the observations, they indicated there was no specific staff scheduled to provide the specific intervention resident #006 required. The Staffing Coordinator reviewed the staffing schedule and indicated that the Long-Term Care Home was short two PSWs, on the shift of the specific date of the observations.

In an interview with Inspector, Co-DOC #2 stated that there was no specific intervention implemented for resident #006 for a period of time of the specific date of the observations. [s. 8. (1) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg 79/10, s. 114 (1), the licensee was required to ensure that written policies and protocols were developed for the medication management system to

ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy regarding "SFP LTC Policy & Procedure v.2.7 – Policy #9.2", which is part of the licensee's medication management system.

A CIS report was submitted to the Director on a specific date, related to a medication incident where it was identified that resident #017 was missing one specific medication tablet. The report identified that RPN #130 was questioned and identified that they could not recall if they gave the resident their ordered dose twice or if they had mistakenly (improperly) discarded the medication.

The home's policy titled "SFP LTC Policy & Procedure v2.7 – Policy #9.2" indicated when removing a specific medication from active supply, two registered staff members, acting together, must indicate the reason for removal/destruction, the remaining quantity and sign/date accordingly on a specific record and document the removal on the shift count. The policy identified that two registered staff members would then place the medication in the designated specific area.

In an interview with Inspector #638, the DOC indicated that they were never able to determine the actual cause of the missing medication and the two possible causes were that the resident received an additional dose of their medication or the RPN improperly disposed a medication. The DOC stated that RPN #130 received teaching related to handling and destruction of specific medications.

Inspector #638 reviewed resident #017's health care records and identified in their progress notes that the physician stated that if the resident was given two doses, they would have an identified side effect, therefore, the physician did not believe that this had occurred. The Inspector reviewed the home's "Medication Incident Form" which identified that RPN #130 also identified incorrect destruction as the potential incident type.

In an interview with Inspector #638, RPN #130 stated they recalled the incident where they were administering medications to resident #017 and had made an error when managing the resident's scheduled medication. The RPN indicated that they were administering medications to the resident and must have placed the resident's scheduled medication in the drug disposal bin by accident. The RPN indicated that the proper process for drug destruction included two registered staff members witnessing and

documenting the drug being disposed of for destruction and in this circumstance, they did not follow proper procedures.

During an interview with Inspector #638, RN #103 indicated that the medication destruction process for this specific medication involved two registered staff members acting together to destroy any medication of this type, that required destruction.

In an interview with Inspector #638, the DOC identified that the proper medication disposal process included two registered staff members signing the medication count sheet to identify why the medication was not given and why it had to be destroyed and the two registered staff members would drop the medication into the disposal box which would then be taken and completely destroyed by the DOC and pharmacist acting together. The DOC stated that RPN #130 was not following the home's medication destruction processes. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff complies with the home's policies titled "SFP LTC Policy & Procedure v.2.7", to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Sexual abuse is defined in the O. Reg. 79/10, as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS report was submitted by the home to the Director. The report outlined how on the previous morning, resident #007 was observed by Housekeeper #107, pushing resident #009 in their mobility assistance device down the hall. Resident #007 had their hands inappropriately placed on resident #009.

The CIS report further outlined how Housekeeper #107 did not intervene at the time and the two residents were not separated until minutes later, when PSW #110 intervened after finding resident #007 in the dining room inappropriately touching resident #009.

Inspector #609 reviewed resident #007's health care records and found in a progress note on the date of the incident that a cleaning staff member had reported to a PSW who then reported to the RPN that the resident was touching another resident inappropriately. The RPN questioned the cleaning staff member, who stated the resident was pushing a resident in their mobility assistance device to the dining room and inappropriately touching the resident.

Resident #007's progress notes further described that shortly thereafter, a PSW on the unit reported to the RPN that they had stopped resident #007 touching resident #009. The resident was inappropriately touching the resident.

The home's policy titled "Resident Rights, Care And Services – Abuse Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, states that any person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager is on site at the home.

During an interview with Inspector #609, Housekeeper #107 described how they observed resident #007 in the hallway. They were leaning over resident #009 inappropriately touching them. The Housekeeper indicated what they witnessed did not "sit well" with them. The Housekeeper indicated that they went back to their duties and did not inform registered staff until 45 to 60 minutes later, after they had spoken with PSW #119, who advised them that they needed to report what they had seen. Housekeeper #107 verified that they had completed the home's 2018 zero tolerance of abuse and neglect of residents training and further verified that they should have

immediately reported what they had witnessed to registered staff.

During an interview with the DOC, a review of the CIS report was conducted. The DOC verified that Housekeeper #107 did not comply with the home's abuse policy when they failed to immediately report the potential sexual abuse of resident #009 by resident #007 on the date of the incident. [s. 20. (1)]

2. A CIS report was submitted to the Director related to an incident which occurred on a specific date, where it was alleged that PSW #110 made a comment towards resident #002, who was "hurt by the comment at the time of the incident".

Emotional abuse is defined in the O. Reg. 79/10 as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Inspector #638 reviewed the internal investigation records and identified a written letter which stated that on the date of the incident, PSW #110 had unacceptable actions and was reprimanded for their conduct.

In an interview with Inspector #638, PSW #110 indicated that they responded to resident #002 on the date of the incident. The PSW stated they were responding to resident who required assistance and described their actions and comments when they walked into resident #002's room. The PSW indicated that the resident became agitated as a result of PSW #110's statement. The PSW stated they clarified what they had meant at the time of the incident to the resident.

During an interview with Inspector #638, RPN #131 indicated that they were working on the date of the incident and became aware of the alleged incident between PSW #103 and resident #002 when they responded to the resident, who was upset because of interaction with PSW #103.

The home's policy titled "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" Last revised June 2017, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization gestures, actions, behaviour performed by anyone other than a resident.

In an interview with Inspector #638, the DOC stated that PSW #110's comments made resident #002 feel bad about requesting assistance. The DOC indicated that PSW #110 received disciplinary action as a result of the abuse and that at the time of the incident staff were not compliant with the home's policy to promote zero tolerance of abuse. [s. 20. (1)]

3. A CIS report was submitted to the Director on a specific date, related to an incident which occurred one day earlier, where PSW #110 made a comment towards resident #002. Please see WN #3, finding #2 for details.

Inspector #638 reviewed the CIS report submitted by the home, which identified that Co-DOC #2 was notified of the incident one day after the incident occurred. The report indicated that education would be provided to registered staff in terms of immediate reporting.

The Inspector reviewed a record of a meeting held with RPN #131. The record identified that RPN #131 had written up the incident of suspected abuse and had not immediately reported the incident. The RPN indicated that they believed they had to write the incident up if it was abuse.

In an interview with Inspector #638, PSW #128 indicated that if they suspected abuse or neglect of a resident, they would immediately report the suspicion to their supervisor. The PSW identified that they could also approach management at any time to report an incident of abuse or neglect.

During an interview with Inspector #638, RPN #131 indicated that they were working on the date of the incident and felt that PSW #110's actions towards resident #002 were abusive. The RPN indicated that staff were supposed to immediately report incidents of abuse to their charge nurse or management.

In an interview with Inspector #638, the DOC indicated that RPN #131 did not immediately notify their charge RN when they became aware of the alleged incident of abuse between PSW #110 and resident #002. The DOC stated that staff were required to immediately report any incident of suspected abuse to management or the charge RN and indicated that RPN #131's actions did not comply with the home's policy to promote zero tolerance of abuse. [s. 20. (1)]

4. A CIS report was submitted to the Director related to care concerns where resident

#004 alleged that PSW #104 was mean to them and did not fully provide all care prior to leaving the resident.

Inspector #638 reviewed internal investigation records and identified a letter of discipline which stated that the resident was not comfortable with PSW #104 providing care and felt they were treated disrespectfully. The Inspector reviewed notes from an interview with resident #004. The notes identified that the resident felt that PSW #104's actions were abusive and they did not want that staff member to care for them anymore.

Inspector #638 interviewed resident #004, who indicated that their care used to be lacking and felt that staff would not assist them with all of their needs. The resident stated that this had improved and care was now being provided, since their concerns were brought forward.

In an interview with Inspector #638, PSW #137 indicated that resident #004 required a certain level of assistance with the majority of their care. The PSW indicated the level of assistance the resident required to complete Activities of Daily Living (ADL) tasks.

During an interview with Inspector #638, RPN #121 indicated that resident #004 required a certain level of staff assistance for their care needs. The RPN indicated that direct care staff were supposed to ensure that the resident received specific care throughout the day.

In an interview with Inspector #638, the DOC stated that the letter was found under their door. Upon completing the investigation the DOC indicated that PSW #104 received disciplinary actions as their approaches towards resident #004 were considered abuse. The DOC stated that PSW #104 was not compliant with the home's zero tolerance of abuse policy as a result of their approaches to resident #004. [s. 20. (1)]

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 staff comply with the home's written policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was received by the Director related to resident #001's skin and wound care.

Inspector #681 reviewed resident #001's electronic treatment record for the period of 77 days and identified that resident #001 was supposed to have a wound note (assessment)

completed for their specific area of altered skin integrity on ten specific dates during the review period.

The Inspector reviewed the progress notes in resident #001's electronic health care record and identified that wound notes were not completed on five of the specific dates during the review period.

During an interview with Inspector #681, RPN #131 stated that all wounds were supposed to be assessed weekly and a wound note was to be completed in the resident's electronic health care record. RPN #131 reviewed resident #001's electronic health care record and stated that a wound note had not been completed for 57 days.

The Inspector reviewed the home's policy titled "Resident Rights, Care, and Services – Skin and Wound Care Program", last revised October 17, 2018, which indicated that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During an interview with Inspector #681, Co-DOC #2 stated that the weekly wound notes should be completed for the area of altered skin integrity on resident #001. Co-DOC #2 acknowledged that wound notes were not completed on four of the identified dates. However, Co-DOC #2 stated that there was a wound note completed on the date of the interview, for resident #001.

2. Inspector #681 reviewed resident #021's electronic treatment records for the period of 47 days and identified that resident #021 was to have a wound note completed for their specific area of altered skin integrity on seven occasions during the review period.

The Inspector reviewed the progress notes in resident #001's electronic medical record and identified that wound notes were not completed on two dates during the review period.

During an interview with Inspector #681, RPN #130 stated that registered staff were supposed to complete a weekly wound note for resident #021's specific area of altered skin integrity. The RPN indicated that if the resident's dressing was dry, registered staff may not remove the dressing to complete the wound assessment and defer the assessment to the next day. The RPN acknowledged that weekly wound notes were missed, despite being signed as completed in the resident's electronic treatment record.

During an interview with Inspector #681, Co-DOC #2 stated that the weekly wound notes should be completed for the wound on resident #021's area of altered skin integrity. Co-DOC #2 acknowledged that wound notes were not completed on two of the dates in the review period. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001, resident #021 and any other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A complaint was received by the Director related to resident #001's skin and wound care. Inspector #681 reviewed the progress notes in resident #001's electronic health records and identified three separate progress notes written by three different RDs during a 45 day period.

During an interview with Inspector #681, the DOC stated that the home had been without

a RD for a period of time, but there were some RDs who provided remote and onsite coverage until the position could be filled by a permanent RD. The DOC stated that during the period of October 2018, to December 2018, there were 126 residents who resided in the home.

Subsequently, based on r. 74 (2) of the Ontario Regulation (O. Reg.) 79/10, and the number of residents who resided in the home, the home was required to have a RD on site for a minimum of 63 hours per month.

Inspector #681 reviewed a letter addressed to RD #111, which indicated that RD #111 contractual agreement with the home was ending.

The Inspector reviewed invoices submitted to the home by an external agency for the period of October 2018, to December 2018. The Inspector also reviewed a summary of the RD coverage, which was provided to the Inspector by the Consulting Nutrition Manager, for the same time period. These documents indicated that for the month of;
-October 2018, RD #143 and RD #111 worked a combined total of 59.5 hours on site and that RD #112 and RD #113 worked an additional 4.5 hours off site;
-November 2018, RD #111 worked a total of 46 hours on site and RD #112, RD #113, and RD #114 worked a combined total of 20 hours off site; and
-December 2018, RD #115 and RD #116 worked a total of 22 hours on site and RD #114 provided an additional 32.5 hours of off site coverage.

During a telephone interview with Inspector #681, RD #114 stated that they worked as a corporate RD for the external agency and that they provided some remote coverage for Elizabeth Centre, while the home was without a permanent RD.

During an interview with Inspector #681, RN #103 stated that there had been a delay in having RD assessments and referrals completed. RN #103 stated that it was "hard to work with [the RD] when you do not see them".

During an interview with Inspector #681, the Administrator stated that RD #111 finished their contract and that RD #117 was starting as the home's new RD on a specific date. The Administrator stated, in the interim, the external agency had arranged for five RDs to provide services to the home. The Administrator stated that some of these RDs were on site and others were completing assessments and referrals off site. The Administrator stated that the home only paid for the services that were provided and that they were aware that some of the RD hours were completed off site. [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #6: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Two complaints were submitted to the Director. The complaints outlined concerns that resident #008, may have been ordered and received a new specific medication without the consent of the SDM.

Inspector #642 identified a progress note created on a specific date, which indicated one of resident #008's SDM had been called about the specific medication order, when the Physician wanted to change the administration frequency. The notation identified the

SDM did not give consent to the new order and then questioned the home on when the specific medication had originally been started, since they had not given consent for the medication.

Inspector #642 reviewed a document titled "Prescriber's Order Form," and found, resident #008 was prescribed a specific medication by a specific route and frequency on a specific date.

The Inspector reviewed resident #008's electronic Medication Administration Record (eMAR) and found that resident #008 had received the specific medication for 28 days prior to the resident's SDM becoming aware.

Inspector #642 reviewed resident #008's progress notes and noted that there was no progress note identifying that resident #008 or their SDM had been informed of the medication change.

Inspector #642 interviewed RPN #106, RPN #139, RN #124 and RN #103, who each stated that it was the home's policy to inform the resident and/or the SDM of any new medication change, right away, to obtain consent for the changes and the registered staff member would document this information in a progress note. The Inspector reviewed resident #008's progress notes with RPN #139. The RPN could not locate any notation indicating that the SDMs had been informed of the new medication order, when it was ordered.

The home's policy titled, "Resident Rights, Care and Services-Plan of Care," last revised March 13, 2018, required the home to ensure that the resident, the resident's substitute decision maker if any, and 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.

Inspector #642 interviewed the DOC, who stated that resident #008's SDMs were not originally involved with the new medication order when it was ordered. Therefore, the licensee did not ensure the SDMs were given an opportunity to participate fully in the development and implementation of the resident #008's plan of care. [s. 6. (5)]

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

A CIS report was submitted to the Director related to a missing medication for resident #013, which was identified when RPN #106 went to administer the residents specific medication on a specific date. The report identified that processes were in place to prevent these incidents from occurring, which included, staff verifying the medication administration method at shift change and applying a specific barrier to ensure that the medication was not easily displaced. The report stated that it was found that both of the interventions were not completed when this incident occurred.

Inspector #638, reviewed resident #013's health care records and identified that the resident was ordered a specific medication to be administered and replaced on a set schedule. The Inspector identified in the eMAR that registered staff were supposed to ensure that the medication was being properly administered at the change of each shift. The task required two registered staff to verify the medication administration three times a day.

The Inspector reviewed the resident's progress notes and identified a notation made on the date of the incident where RPN #106 identified that they were unable to verify the resident's specific medication administration method and identified that the registered staff member who administered the medication three days prior, did not apply the specific barrier.

The Inspector reviewed the home's letter of discipline for RPN #131, which identified that on the date of the incident resident #013's specific medication was missing and during the investigation it was noted that all of the nurses on all of the shifts leading up to the missing medication had signed off that the medication had been seen. The letter stated that "you and one of your peers (RN #135) both admitted that you had not actually [verified] the [specific medication] despite the fact that you had signed off that you had".

In an interview with Inspector #638, RPN #106 indicated that two registered staff members were supposed to verify the specific medication that was being administered to a resident, on each shift and document the administration on the eMAR. The RPN stated even if they could not verify the medication administration, registered staff should document rationale identifying why they could not complete their verification and that staff could not just document it as completed.

Inspector #638 interviewed RPN #131, who indicated that registered staff were to verify each resident's medication with both the oncoming and outgoing registered staff member and document the verification in the eMAR. The RPN stated that they were made aware

that resident #013's specific medication had gone missing and they admitted to not verifying the medication administration as per the resident's plan of care and just signed the verification as completed. The RPN acknowledged they should have been completing all required verifications identified in a resident's plan of care.

During an interview with Inspector #638, RN #127 and RN #103 both indicated that they were required to verify the resident's specific medication administration with two registered staff members (oncoming and outgoing staff at shift change) on each shift. RN #103 stated that staff were required to follow the resident's specific eMAR for planned medication administration.

The home's policy titled "Resident Rights, Care and Services – Plan of Care" last revised March 2018, states that registered staff will ensure care is provided to the residents as specified in the plan of care.

In an interview with Inspector #638, the DOC indicated that staff were expected to complete resident care as per the resident's planned care. The Inspector reviewed the incident where it was identified that the registered staff were not verifying the specific medication for administration and documenting it as done. Upon review, the Inspector inquired if staff were providing the planned care to resident #013, as it was laid out within the plan of care, the DOC stated no. [s. 6. (7)]

Issued on this 1st day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RYAN GOODMURPHY (638), AMY GEAUVREAU (642), CHAD CAMPS (609), STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2019_679638_0002
Log No. / No de registre :	020484-18, 023445-18, 023645-18, 024700-18, 025091-18, 025160-18, 025482-18, 031360-18, 031408-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 29, 2019
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To Valley East Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (2) (b) of the LTCHA, 2007. Specifically, the licensee must;

a) ensure that the organized program of personal support services for the home meets the assessed needs of the residents;

b) develop and implement a plan to ensure that when residents require a specific intervention, that the assigned staff member is aware of their responsibilities and not pulled from their duties; and

c) maintain a record to monitor when a resident has the specific intervention implemented and who provided the monitoring, for every resident who requires the specific intervention.

Grounds / Motifs :

1. The licensee has failed to ensure that the organized program of personal support services for the home met the assessed needs of the residents.

A) A CIS report was submitted by the Long-Term Care Home to the Director which outlined that on a specific date resident #007 was found inappropriately touching resident #011.

Inspector #609 reviewed resident #007's health care records and identified a

progress note created three days prior to the specific incident, which indicated that RN #124 called the resident's family and requested they take the resident out of the Long-Term Care Home for a period of time. In another progress note created the date the incident occurred, RN #138 had advised the resident's Substitute Decision Maker (SDM) that they needed to take the resident with them, out of the Long-Term Care Home, or they would call an external agency to have the resident removed.

During an interview with Inspector #609, RN #138 verified what they had told resident #007's family. The RN stated that the DOC told them that under no circumstances was the resident to return to the Long-Term Care Home until management had made a decision regarding resident #007. RN #138 stated that the family had taken the resident out of the Long-Term Care Home. The RN verified that, despite a call from resident #007's SDM one day after taking the resident out of the Long-Term Care Home, they were indicating that they had to return the resident to the Long-Term Care Home, they (the RN) refused to allow them to bring the resident back to the Long-Term Care Home.

The Long-Term Care Home's policy titled "Resident Rights, Care and Services – Nursing and Personal Support Services – Staffing Plan" indicated that the written staffing plan included a staffing mix that was consistent with residents' assessed care and safety needs that met the requirements set out in the Act and Regulation.

During an interview with Inspector #609, the DOC verified that RN #138 was given instructions to tell resident #007's SDM that if they did not remove the resident from the Long-Term Care Home, that they would send the resident to an external agency. The DOC outlined how the Long-Term Care Home was very short staffed those specific dates and there was no staff to provide a specific intervention resident #007 required to ensure the safety of other residents.

A review of the Long-Term Care Home's unfilled shift report for the specific dates the incident occurred and found that the Long-Term Care Home was short nine PSW shifts on one date and 10.5 PSW shifts on the second date.

B) A CIS report was submitted by the Long-Term Care Home to the Director on a specific date, which outlined how at a specific time resident #007 was found

inappropriately touching resident #012.

Inspector #609 reviewed resident #007's health care records and found in their plan of care, the resident required two specific interventions implemented, activated at all times and were to be provided a specific intervention when they were out of their room. The Inspector identified a progress note on the date of the incident which stated that PSW #142 did not activate the resident's specific intervention and allowed the resident to leave their room without implementing the specific intervention.

The Long-Term Care Home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of Care" last revised March 13, 2018, indicated that care was to be provided to the resident as specified in the plan of care.

During an interview with Inspector #609, PSW #142 verified that they did not review resident #007's plan of care prior to providing care. The PSW described they were short one RPN on a specific shift on the specific date of the incident, which resulted in no shift to shift report being conducted, which was the typical way that changes in residents' plans of care were communicated to the oncoming shift. They were also working short one PSW and did not have time to review the residents' plans of care before providing care.

A review of the Long-Term Care Home's unfilled PSW shifts found that the Home Area was short one RPN on one specific shift and one PSW on the other specific shift on the specific date of the incident.

C) Two complaints were submitted to the Director which outlined concerns that the family of resident #007 had to accommodate a specific intervention privately for the resident. The complaints alleged this was because the Long-Term Care Home lacked the staff necessary to provide the resident's specific intervention.

Inspector #609 reviewed a CIS report that was submitted by the Long-Term Care Home to the Director on a specific date, which indicated resident #007 was to have received a specific intervention after the resident was found a second time, inappropriately touching resident #009.

A review of resident #007's health care records identified a progress note on the

date of the incident, which indicated that the resident received a specific intervention after an incident of inappropriate touching.

During an interview with Inspector #609, the complainant described being told by staff that the family needed to provide the specific intervention to resident #007 or hire someone privately, because the Long-Term Care Home lacked the staffing.

Inspector #609 reviewed resident #007's health care records and found a progress note dated, three days after the incident, which outlined that the resident's SDM refused to take the resident out of the Long-Term Care Home on the specific dates, when staff first asked them, because of safety concerns.

During an interview with Inspector #609, the RFSC verified that they had provided resident #007's SDM with a list of private pay agencies to assist with the specific intervention because the Long-Term Care Home lacked the resources to provide.

During an interview with Inspector #609, the DOC verified that the family was advised by staff that someone was required to implement a specific intervention for resident #007 and suggested they hire an external agency to provide the care, because the Long-Term Care Home did not have the staff to provide the resident's required specific intervention.

D) During interviews with Inspector #609, the DOC and Co-DOC #1 could not produce documentation to support when or what staff provided resident #007's specific intervention. In another interview with the DOC, they verified that resident #007 was to receive the specific intervention on the specific date of the incident, after the second CIS report was submitted.

Inspector #609 reviewed resident #007's health care records and found in a progress note that stated staff should not be pulled from providing the resident's specific intervention.

During an interview with the Staffing Coordinator, a review of the Long-Term Care Home's unfilled PSW shifts for a three month period in 2018, and found that the Long-Term Care Home was short staffed PSWs, every day, within the

three month review period. The Inspector further reviewed the unfilled PSW shifts and found that there was;
-174 unfilled PSW shifts in the first month;
-202 unfilled PSW shifts in the second month; and
-153 unfilled PSW shifts in the third month.

In an interview with Inspector #609, the Staffing Coordinator acknowledged that there was currently no way for the Long-Term Care Home to track if the staff assigned to provide resident #007's specific intervention were pulled from providing resident #007's specific intervention.

A review of four CIS reports submitted by the Long-Term Care Home to the Director found that resident #007, did not have their required specific intervention implemented at the time of two of the four CIS reports. [s. 8. (1) (b)]

2. A complaint and a CIS report were submitted to the Director, on specific dates, which identified resident #006 as having an increase in specific responsive behaviours and the complainant was concerned for the safety of other residents and staff in the Long-Term Care Home.

Inspector #642 reviewed resident #006's progress notes and noted that the resident was returning to the Long-Term Care Home, on a specific date after an absence. The Inspector, further reviewed the progress notes and on a specific date three days prior to their expected return date, the Behavioural Support Ontario-Registered Practical Nurse (BSO-RPN), had identified that resident #006, had assessments completed and was recommended for a specific intervention that was to be implemented when the resident returned to the Long-Term Care Home.

On a specific date, one day after their readmission, Inspector #642 observed the Home Area, where resident #006 resided. The Inspector arrived on the unit at 0911 hours and identified that the resident was still in their room sleeping. At that time, the Inspector identified there was no specific intervention implemented outside or near resident #006's room.

Inspector #642 interviewed RPN #121 on the specific date of the observations. The RPN stated the specific intervention was not implemented for resident #006

and they were aware of the resident's responsive behaviours.

The Inspector interviewed RN #124 on the specific date of the observations. The RN stated they did not have the specific intervention implemented because of staffing availability at that time. The RN stated they would have available staff at a different shift.

Inspector #642 interviewed the Staffing Coordinator, and after reviewing the staffing schedule for the specific date of the observations, they indicated there was no specific staff scheduled to provide the specific intervention resident #006 required. The Staffing Coordinator reviewed the staffing schedule and indicated that the Long-Term Care Home was short two PSWs, on the shift of the specific date of the observations.

In an interview with Inspector, Co-DOC #2 stated that there was no specific intervention implemented for resident #006 for a period of time of the specific date of the observations.

The severity of this issue was determined to be a level two, as there was the potential for actual harm to the residents of the home. The scope of the issue was a level two, as it was identified that multiple incidents of inappropriate behaviours had occurred while the resident was supposed to have a specific intervention in place and placed residents at an increased risk to be abused. The home had a level two compliance history, as they had no previous non-compliance within this section of the LTCHA, 2007. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 29th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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