Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 22, 2017	2017_414110_0002	029314-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 MARY STREET CREEMORE ON L0M 1G0

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

DIANE BROWN (110), SIMAR KAUR (654), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 2017.

The following complaint intake was inspected during this RQI:
Log #001329-17 related to responsive behaviours and an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Registered Dietitian (RD), Director of Dietary Services (DDS), Dietary Aide (DA), Cook, Activity Aide (AA), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Relations Coordinator, Personal Support Workers (PSW), Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **2 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

During stage one of the Resident Quality Inspection (RQI) resident #024 complained that resident #022 has identified responsive behaviours which scare many residents. Residents are fearful that the current specified intervention may not continue. Review of an intake revealed an anonymous staff member complained on an identified date that resident #022 demonstrates identified inappropriate responsive behaviours towards other residents and, in one incident, towards resident #023 that the home did nothing about it.

Record review revealed resident #022 was admitted to the home on an identified date with a specified diagnosis. Record review and interview with the DOC revealed resident #022 was admitted having a specified medical condition. Interview with the DOC revealed that although the specified medical condition improved, resident #022 started having responsive behaviours which began about two months after admission, and had been escalating despite readjustments in medications.

Record review revealed resident #023 was admitted to the home on an identified date with a specified diagnosis. Record review and interviews revealed resident #023 can demonstrate identified responsive behaviours in response to the identified behavioral triggers.

Review of progress notes for both resident #022 and #023 revealed there were seven incidents during an identified two-month period where there were altercations between the two residents. Interviews and record review revealed there was an altercation between these residents whereby resident #022 demonstrated an identified inappropriate action towards resident #023.

Interview with resident #024 revealed resident #022 demonstrated an identified inappropriate action towards resident #023 on an identified date, and resident #023 was in distress. Interview with PSW #109 revealed he/she heard the altercation between resident #022 and #023 and saw resident #022 demonstrating an identified inappropriate action towards resident #023. Record review and interview with RPN #102 revealed

resident #023 did not have any physical injury related to this altercation. Interviews with the DOC and ED confirmed the home did not report this as a critical incident to the MOHLTC or contact the police due to no physical injury. Record review and interviews revealed that following this incident, two identified interventions were implemented for resident #022.

Record review and interviews with RPNs #105 and #107 revealed the physician recommended the first identified intervention for resident #022 on an identified date. According to RPN #107, it did not take place because an identified external specialized resource had not been consulted. According to the DOC, he/she wanted the specialized resource to assess if this intervention might be detrimental for resident #022.

Record review and interview with RPN #105 revealed the physician recommended the second identified intervention on an identified date, but according to the physician's note discussions with the DOC indicated the home did not have the specified resources to implement this. Record review and interview with RPN #107 revealed the physician again recommended the intervention on another identified date due to recurrent of the identified responsive behaviours. This recommendation was documented in the progress notes and also written as a physician order. Record review and interview with RPN #107 revealed the physician again recommended the intervention as the behaviours continued and could escalate. In all these instances the physician was also monitoring and altering resident #022's medications.

Interview with the DOC revealed he/she did not implement the second identified intervention as recommended by the physician because he/she did not feel there was a safety risk and the intervention might not have had the desired effect. The DOC did indicate he/she could have mentioned the home did not have the specified resources as impediments. The DOC did not feel the above mentioned first intervention would have prevented altercations as both residents gravitate towards one another. The DOC confirmed that in hindsight the second identified intervention should have been implemented and most probably would have prevented the physical altercation between resident #022 and #023.

The home failed to implement the interventions identified by the physician to minimize the risk of altercations between resident #022 and #023.

The severity of the non compliance is a potential for harm or risk. The scope is isolated to resident #022 and the home has a history of non compliance in this area issued during

inspection 2015_334565_0019 November 18, 2015. [s. 54. (b)] (501)

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #003 was triggered during stage one of the RQI for falls prevention.

Record review of resident #003's progress notes revealed that the resident had a fall on an identified date resulted in an identified significant injury. Further review of the progress notes indicated the resident was transferred to the hospital on the next day and was readmitted to the home seven days later.

Record review of resident #003's Physiotherapy assessment after his/her readmission from the hospital indicated that he/she required a specified number of staff assistance using an identified device for transfers.

Record review of resident #003's written plan of care indicated that he/she required another specified number of staff assistance for toileting, and used an identified mobility device for ambulation with specified staff assistance.

During observations on two identified dates, resident #003 was observed in a wheelchair, wheeled by a staff member.

Interview with the PSW #123, PSW #128 and RPN #105 confirmed that resident #003 required the specified staff assistance and the identified device, stated in the Physiotherapy assessment, for toileting and transfers since he/she had the above mentioned injury. Staff further confirmed that the resident had been using wheelchair with one staff assistance, and did not use the identified mobility device for ambulation. PSW #123, PSW #128 and RPN #105 further confirmed that the resident's written plan of care did not provide clear directions to staff regarding the resident's assistance of daily living (ADLs).

Interview with the DOC confirmed the resident #003's assistance level had changed after the above mentioned fall, and his/her written plan of care had not been revised. DOC further confirmed that resident #003's plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)] (654)

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

Resident #005 was triggered during stage two of the RQI for skin and wound care.

Record review of resident #005's Minimum Data Set (MDS) assessment dated an identified date indicated an identified altered skin integrity.

Review of Resident Assessment Protocol Summary (RAPs), dated the same date, and progress notes indicated the identified altered skin integrity for resident #005 and a treatment assessment record (TAR) was initiated.

Record review of resident #005's TAR indicated a specified treatment for the resident.

Further review of resident #005's TAR and progress notes revealed that his/her treatment had not been documented on three identified dates.

Interview with RPN #129 confirmed that the altered skin integrity on resident #005 was identified on the day before the above mentioned MDS assessment. Resident #005 had the specified treatment. RPN #129 confirmed that he/she had worked on one of the three identified dates and did not perform the required treatment on resident #005, on that date, due to a time constraint.

Interview with RPN #126 confirmed that he/she had worked on the other two identified dates and did not perform the specified treatment on resident #005, as required on these dates.

Interview with the DOC confirmed that the treatment was not given to resident #005 on three identified dates as specified in his/her plan of care. [s. 6. (7)] (654)

3. Resident #002 was triggered during stage one of the RQI for skin and wound care.

Record review of resident #002's MDS assessment indicated history of resolved altered skin integrity.

Record review of resident #002's plan of care indicated the resident was at risk for altered skin integrity. A specified treatment was put in place for the identified area for the resident.

Record review of resident #002's health record indicated a physician order for the above mentioned treatment on an identified date.

During multiple observations on two identified dates, resident was observed sitting in his/her wheelchair without the specified treatment in place.

Interviews with resident #002 on two identified dates revealed that he/she had the altered

skin integrity which caused pain when he/she sits in a wheelchair. Resident #002 further revealed that he/she did not have the specified treatment for his/her identified area.

Interview with RPN #102 confirmed that the resident had the altered skin integrity, and he/she had a physician order for the treatment mentioned above. RPN #102 and PSW #109 confirmed that resident #002 did not have the treatment when he/she was sitting in his/her wheelchair on one of the above observation dates. RPN further confirmed that resident #002's was not provided care according to his/her plan of care.

Interview with ADOC and Lead for Skin and Wound Care Program revealed that resident #002 had a risk for altered skin integrity. ADOC further mentioned that resident #002 had the altered skin integrity and required the specified treatment. He/she further confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan.

Interview with DOC confirmed that the home's expectation was to provide care as specified in the resident's plan of care and further confirmed that resident #002's care was not provided as specified in his/her plan of care. [s. 6. (7)] (654)

4. Resident #004 was triggered during stage one of the RQI for an identified health condition.

Record review identified resident #004 was at risk for the identified health condition. Further record review revealed the identified health condition in an identified one-year period.

Record review of the RD's documentation revealed that in response to referrals related to the identified health condition on six identified dates, the resident was receiving a specified nutritional intervention.

Review of the medication administration record for four identified months revealed the nutritional intervention, although included in the record, was not documented as ever having been received. Interviews with RPN #107 confirmed resident #004 was not receiving the nutritional intervention. Review of the physician's order with RPN #107 revealed the nutritional intervention was originally ordered on an identified date, however, there was no evidence that it had ever been provided as it had been inaccurately processed.

An interview with the DOC confirmed that resident #004 did not receive the care set out in the plan of care since the nutritional intervention originally ordered by the physician was not processed. [s. 6. (7)] (110)

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #004 was triggered during stage one of the RQI related to a fall.

Record review of the progress notes identified that resident #004 fell on an identified date. A review of the post fall huddle assessment dated the same date revealed a specified falls prevention intervention.

Record review of the resident's plan of care and kardex following the fall failed to identify this intervention.

Observations of resident #004 on an identified date identified the intervention was not implemented for the resident.

Interviews with PSWs #120 and #106 were unaware of the revised intervention following the resident's fall.

Interviews with registered staff #121 and #107 confirmed that the registered staff are expected to update the plan of care after the post fall huddle assessment and that the resident's plan of care was not updated as required.

The DOC confirmed that after resident #004's fall, his/her plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)] (110)

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Resident #004 was triggered during stage one of the RQI for an identified health condition.

Record review revealed resident #004 had the identified health condition in an identified

eight-month period.

Review of the MDS assessment revealed the resident was receiving a specified diet. The resident was at risk for an identified care area. The documentation revealed the resident received a specified nutritional intervention. The care plan goal was for preventing the identified health condition.

Record review revealed that on an identified date, the RD responded to a referral related to the identified health condition and an altered skin integrity by acknowledging the resident was receiving a specified nutritional intervention.

Record review revealed that on an identified date in the next month, the RD responded to a referral related to the identified health condition in the past month. The note revealed resident #004 was already receiving the specified nutritional intervention. No changes to the plan of care were recommended.

Record review revealed the resident continued to have the identified health condition on an identified date in the following month.

Review of the medication administration record (MARs) for three identified months revealed the nutritional intervention, although included on the MARs, was not documented as ever having been received.

Interviews with RPN #107 confirmed resident #004 was not receiving the nutritional intervention. Review of the physician's order with RPN #107 revealed the nutritional intervention was originally ordered on an identified date, however there was no evidence that it had ever been provided as it had been inaccurately processed.

An interview with the RD identified an unawareness that the nutritional intervention had not been provided to resident #004 since ordered. An interview with the DOC confirmed that the resident never received the nutritional intervention since originally ordered by the physician, and no one assessed the documented administration and/or acceptance of the nutritional intervention which would have revealed that it was never provided.

The home has failed to ensure that the nutritional intervention was evaluated for effectiveness when resident #004 was reassessed for continuously having the identified health condition.

The severity of the non compliance is actual harm or risk. The scope is isolated to resident #004 and the home has no history of non compliance in this area. [s. 6. (10) (c)] (110)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written plan of care for each resident the sets out clear directions to staff and others who provide direct care to resident, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Resident #001 triggered during stage one of the RQI for an identified health condition.

Record review revealed that resident #001 had the identified health condition over an identified five-month period.

Review of the MDS, RD assessment on an identified date, identified the resident’s specified intake. The assessment confirmed that resident’s intake had a specified change and identified that a specified nutritional intervention would be added if needed.

Review of resident’s progress notes revealed a referral for the identified health condition was made on two identified dates in two consecutive months.

Review of the home’s policy #XI-G-20.50 titled, Nutritional Supplement Guidelines, revised January 2015, revealed the RD will complete a comprehensive nutritional assessment and review the food and fluid monitoring records upon receipt of a referral. The policy further stated the RD will recommend the first nutritional approach to include the Plus Program for food first; determine if dining environment is conducive to adequate intake and report to care team for any required changes; review if resident requires more assistance and communicate with the team and request more frequent weights if applicable.

Record review revealed a dietary referral response by the RD as follows: DDS referral related to the identified health condition. Order done for a specified nutritional intervention.

An interview with the RD confirmed he/she did not complete an assessment for the above referral prior to implementing the specified nutritional intervention. The RD revealed he/she implemented the intervention as he/she needed to add "something" as soon as possible. The RD confirmed that he/she relied on the specified nutritional intervention to add more calories as other interventions are not as reliably implemented.

Interview with the DDS confirmed the dietary department does not use the Plus Program as indicated within the home's above mentioned policy, and that the RD prefers the use of the mentioned nutritional intervention. [s. 8. (1) (a),s. 8. (1) (b)] (110)

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 home's policy Nutritional Supplement guidelines, related to dietary services, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home assesses the matters referred to in paragraph 13 of section (3). Section (3) identifies that a plan of care must be based on at minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risk relating to nutritional care.

Resident #001 triggered during stage one of the RQI for an identified health condition. Record review revealed that resident #001 had the identified heath condition in an identified five-month period.

Review of the MDS, RD assessment on an identified date identified the resident's specified intake. The assessment identified that a specified nutritional intervention would be added if needed.

Staff interview with PSW #106, assigned to resident at meals, confirmed resident #001 needs a specified intervention for eating.

Record review revealed the identified health condition and referrals related to nutritional risk as follows:

• Progress note revealed on an identified date, the DDS documented that resident's dietary care plan was reviewed and an identified nutritional risk was noted. The DDS confirmed the resident's identified nutritional risk was not assessed.
• An identified report indicated the resident had the identified health condition on two identified dates. The DDS confirmed the resident's identified health condition was not assessed.
• An identified report indicated on another identified date, the resident had the identified health condition. Progress note revealed nine days later, the DDS sent a dietary referral to the RD to assess the identified health condition.

•Progress note revealed that two days later, the RD ordered a specified nutritional intervention at a specified time period prior to completing a nutritional assessment.
An identified report revealed that in the following month, the resident continued to have the identified health condition.
• An identified report revealed that during the one-month period after the nutritional intervention was ordered, the resident refused the intervention in a specified significant manner.
• Physicians order noted on an identified date during this period, to treat an identified altered skin integrity.
• Progress note two days later revealed the RD received a referral regarding the altered skin integrity. The documentation revealed that the resident was receiving the nutritional intervention at two specified time periods for the identified health condition and it would help promote wound healing quickly.

Record review and an interview with the DDS revealed the specified nutritional intervention at the second time period was never implemented for resident #001.

An interview with the RD confirmed the resident was to receive the specified nutritional intervention at the two specified time periods for the identified heath condition and altered skin integrity. The RD revealed he/she was unaware the resident was not receiving the intervention at the second time period. The RD further identified an unawareness that the resident had refused the intervention in the specified significant manner since implemented. The interview with the RD confirmed that a nutritional assessment was not completed for identifying the risks to the resident's nutritional care prior to implementing

the nutritional intervention as mentioned above.

The RD failed to ensure the specified risks related to the resident's nutritional status were assessed. [s. 26. (4) (a),s. 26. (4) (b)] (110)

2. Resident # 004 triggered during stage one of the RQI for an identified heath condition.

Record review revealed that the resident had the identified heath condition in an identified six-month period.

Review of the progress notes on three identified dates revealed the RD responded to referrals related to the identified heath condition but did not include resident #004's energy needs compared to energy intake. It was unclear if adequate energy to compensate for the identified heath condition was being provided to achieve the goal.

Interview with the RD confirmed that his/her assessments were not documented and are often a summary statement in the progress notes. The RD verbally identified that the menu provided 2700 calories if all is taken and his/her assessment of percentage taken was based on this total number of calories. A review of the home's policy #XI-G-10.30 titled Overview of Diet and Nutrition Program Interventions revised October 2015, revealed the menu (which included three daily snacks) provided approximately 2200 calories. This discrepancy presents a risk to resident #004's nutritional status.

Observation during lunch and afternoon snack on January 23, 2017, revealed resident #004 was served a specified diet.

Record review of the MDS, RD assessment, and the RD statement in the interdisciplinary care conference note revealed resident #004 was on another diet, but not the above specified one.

Interview with PSW #122 revealed the resident's diet was changed from another diet to the specified diet since long time ago. Dietary aide #118 confirmed the resident was the specified diet for a long time and that the dietary kardex identified that the resident was on the specified diet. PSW #120 stated the resident had an identified health condition and was not eating well. Interview with the RD revealed the resident was on another diet.

Review of a dietary referral from the DDS on an identified date revealed the resident's

specified meal acceptance.

An interview with the RD confirmed the resident was known to have the mentioned meal acceptance and identified his/her unawareness that the resident was receiving the specified diet. Following inspector's interview with the RD, resident #004 was placed back on another diet. An interview with the DDS revealed that the resident ate everything up at breakfast on an identified date afterwards, and was eating a lot better on another diet according to dietary aide #118.

The RD failed to identify an unassessed downgraded diet being served to the resident and the impact on the resident's meal acceptance, overall intake and contribution to resident's identified health condition.

Review of the progress notes revealed that the RD responded to referrals for resident #004's altered skin integrity on two identified dates. During the first one, the RD responded to an identified altered skin integrity by stating the resident was receiving a specified nutritional intervention. During the second one, the RD responded to another identified altered skin integrity by stating again the resident was receiving the same specified nutritional intervention.

Review of the home's policy #XI-G-30.10 titled Nutrition and Wound Care revised January 2015, stated the RD will complete a nutritional assessment for the resident which will include an assessment of energy, protein and fluid requirements and the need for vitamin and mineral supplements.

An interview with the RD revealed his/her documentation would often be a summary and he/she calculates energy, protein and fluid requirements for residents on admission. The RD also revealed he/she was unaware resident #004 was not receiving the specified nutritional intervention as ordered. During the interview, the RD identified an additional intervention for resident #004. Record review of the plan of care, kardex and servery report failed to identify this intervention for resident #004. Interview with PSW #122 who regularly assisted resident #004 at breakfast and lunch was unaware of this additional intervention. The RD failed to assess the risk and impact of altered skin integrity on resident #004's nutritional status. [s. 26. (4) (a),s. 26. (4) (b)] (110)

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 assesses a residents nutritional status, including height, weight and any risk relating to nutritional care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations between and among residents.

During stage one of the RQI an interview with resident #025 revealed that resident #023 demonstrated an inappropriate responsive behavior towards him/her. Resident #025 told the inspector that this incident made him/her feel unsafe and it was disturbing. Resident #025 brought this to the attention of PSW #112 but had not spoken to management about this.

Review of resident #023's progress notes revealed the above mentioned incident. Interview with PSW #112 revealed this incident happened when he/she was busy tending to another resident and the staff who resident #023 approached was unaware how to redirect resident #023. Record review and interview with resident #025 revealed the resident did complain to the ED regarding this incident only after speaking with the inspector in stage one of the RQI. Resident #025 revealed that he/she felt helpless because of his/her physical impairments. According to the ED he/she did not view this as a complaint because he/she felt he/she dealt with the issue and resident #023 was not feeling unsafe.

Interview with resident #025 revealed he/she did not feel his/her concern was addressed and it was simply left up in the air as to what could be done to prevent a reoccurrence.

Interviews with residents #026 and #027 revealed resident #022 entered their room around the same time resident #022 had an altercation with resident #023. Interviews with resident #026 and #027 revealed resident #022 demonstrated inappropriate actions towards them, and resident #027 was afraid. Resident and staff interviews revealed this incident made them so upset they went to speak with management but were told they were in a meeting and would get back to them. Interview with resident #026 revealed no one had ever gotten back to him/her but interview with resident #027 revealed someone had gotten back to him/her to reassure him/her. Interview with the DOC revealed he/she did speak with resident #026 and resident #026's SDM about the incident and both were feeling reassured.

Interview with RPN #105 revealed residents have told him/her that they are afraid to close their eyes and go to sleep. RPN #105 also stated some residents have gone to management to complain but they think it is like talking to a brick wall.

Interview with the DOC revealed that he/she recalls residents complaining to him/her regarding residents with responsive behaviours but feels it is not always ethical to explain what specific measures are being implemented due to privacy concerns. The DOC indicated that staff on night shift should know where all residents are at all times and take measures to prevent altercations. Interview with the ED revealed he/she does not feel it is possible to ensure residents with responsive behaviours do not enter the rooms of other residents.

The home has failed to make residents feel safe by failing to develop and implement procedures and interventions to assist residents and staff who are at risk of harm and to

minimize the risk of altercations and potentially harmful interactions among residents as evidenced by residents displaying responsive behaviours being able to enter and intimidate residents who are trying to rest. [s. 55. (a)] (501)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations between and among residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.

Resident #002 triggered from stage one of the RQI for weight change. Record review revealed an identified weight change over an identified six-month period.

Record review further revealed the resident had identified significant weight changes in three identified six-month periods.

Record review revealed the significant weight change in an identified month was not assessed by either nursing or dietary and interview with the DDS confirmed dietary did not receive a referral regarding the weight change and the RD was unable to confirm an assessment was completed. Interview with the DOC confirmed nursing did not assess the resident's significant weight change in three identified months. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (110)

2. Resident #001 triggered from stage one of the RQI for weight change. Record review revealed that the resident had an identified weight change over an identified five-month period.

Record review further revealed the resident had identified significant weight changes in two identified one-month, three-month, and six-month periods respectively.

Record review failed to identify an assessment was completed by an interdisciplinary team. Interviews with the DDS, RD and DOC confirmed there was a lack of an interdisciplinary assessment regarding the above noted significant weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (110)

3. Resident #004 triggered from stage one of the RQI for weight change. Record review revealed that the resident had weight change over an identified six-month period.

Record review further revealed the resident had identified significant weight changes in three identified three-month and six-month period respectively.

Record review failed to identify an assessment was completed by an interdisciplinary team. Interviews with the DDS, RD and DOC confirmed there was a lack of an

interdisciplinary assessment regarding the above noted significant weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (110)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with weight changes are assessed, as required, using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the food production system must, at a minimum, provide for standardized recipes and production sheets for all menus.

Resident #004 was triggered during stage one of the RQI for an identified health condition. A meal time observation identified resident #004 received a specified diet.

Record review identified a food item as a menu choice for lunch on an identified date.

Lunch observation on that day identified that another food item was served.

Staff interviews with dietary aide #118 and cook #135 confirmed the food item prepared was not the one on the menu. An interview with cook #135, who prepared the lunch meal on the identified date revealed that he/she followed the recipe for the menu food item. He/she identified the recipe did not yield a desirable product and that he/she had to substitute with another food item at the last minute.

Record review of menu food item recipe identified two specified ingredients and amounts, and specified preparation steps.

Interview with DDS revealed that on Boxing Day it was the same menu and that he/she and the cook followed the same recipe for the menu food item on that day. The DDS revealed that the recipe resulted in the same issue whereby they had to dilute it with gravy and it had more gravy flavour than the menu food item.

The DDS confirmed that the recipe for the menu food item was not standardized. [s. 72. (2) (c)] (110)

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 the food production system must, at a minimum, provide for standardized recipes and production sheets for all menus, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of receiving Family Council advice related to concerns or recommendations that a written response is provided.

Record review of the Family Council meeting minutes of an identified date, one of the last three meetings at the home, identified a family concern. The concern documented was related to residents who were seated at the dining room table by the front door felt cold.

Interview with resident relations coordinator revealed that the issue was brought up with the management team but a form was not completed and a response was not provided back to Family Council. [s. 60. (2)] (110)

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident offered a minimum of a snack in the afternoon. Resident #001 triggered during stage one of the RQI for an identified health condition.

Record review revealed the resident had the identified health condition over an identified five-month period. The resident was identified at nutritional risk.

The afternoon snack service was observed on an identified date. Resident #001 was observed being provided with his/her nutritional supplement and not offered the PM drink and snack choice by PSW #116.

An interview with PSW #116 confirmed that he/she did not offer the PM snack choice on the identified date however, revealed awareness that he/she should have offered resident #001 the choice. [s. 71. (3) (c)] (110)

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), SIMAR KAUR (654), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_414110_0002
Log No. / Registre no:	029314-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2017
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 MARY STREET, CREEMORE, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula Rentner

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT 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 :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The home must ensure that the following are in place for residents with responsive behaviours including resident #022:

1. Implement intervention of one to one nursing staff when recommended by the attending physician and/or psychogeriatric expert.
2. Initiate immediate steps when a resident is identified as a trigger for the responsive behaviours of another resident. Steps to include but not limited to room changes, timing of meals, table placement in the dining room, minimizing interactions in the hallways and strategies to prevent residents with responsive behaviours from entering other resident rooms.
3. Regular evaluation of the effectiveness of the immediate steps taken to mitigate the triggers for responsive behaviours.
4. Assess the quality of the home's education for all direct care nursing staff in the area of responsive behaviours by surveying staff on their confidence in dealing with difficult responsive behaviours. Based on this assessment, access specialized resources to implement comprehensive training including formalized in- servicing with mandatory attendance for all direct care staff. Maintain records of the survey, assessment, education content and attendance records.

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying

and implementing interventions.

During stage one of the Resident Quality Inspection (RQI) resident #024 complained that resident #022 has identified responsive behaviours which scare many residents. Residents are fearful that the current specified intervention may not continue. Review of an intake revealed an anonymous staff member complained on an identified date that resident #022 demonstrates identified inappropriate responsive behaviours towards other residents and, in one incident, towards resident #023 that the home did nothing about it.

Record review revealed resident #022 was admitted to the home on an identified date with a specified diagnosis. Record review and interview with the DOC revealed resident #022 was admitted having a specified medical condition. Interview with the DOC revealed that although the specified medical condition improved, resident #022 started having responsive behaviours which began about two months after admission, and had been escalating despite readjustments in medications.

Record review revealed resident #023 was admitted to the home on an identified date with a specified diagnosis. Record review and interviews revealed resident #023 can demonstrate identified responsive behaviours in response to the identified behavioral triggers.

Review of progress notes for both resident #022 and #023 revealed there were seven incidents during an identified two-month period where there were altercations between the two residents. Interviews and record review revealed there was an altercation between these residents whereby resident #022 demonstrated an identified inappropriate action towards resident #023.

Interview with resident #024 revealed resident #022 demonstrated an identified inappropriate action towards resident #023 on an identified date, and resident #023 was in distress. Interview with PSW #109 revealed he/she heard the altercation between resident #022 and #023 and saw resident #022 demonstrating an identified inappropriate action towards resident #023. Record review and interview with RPN #102 revealed resident #023 did not have any physical injury related to this altercation. Interviews with the DOC and ED confirmed the home did not report this as a critical incident to the MOHLTC or contact the police due to no physical injury. Record review and interviews revealed that following this incident, two identified interventions were

implemented for resident #022.

Record review and interviews with RPNs #105 and #107 revealed the physician recommended the first identified intervention for resident #022 on an identified date. According to RPN #107, it did not take place because an identified external specialized resource had not been consulted. According to the DOC, he/she wanted the specialized resource to assess if this intervention might be detrimental for resident #022.

Record review and interview with RPN #105 revealed the physician recommended the second identified intervention on an identified date, but according to the physician's note discussions with the DOC indicated the home did not have the specified resources to implement this. Record review and interview with RPN #107 revealed the physician again recommended the intervention on another identified date due to recurrent of the identified responsive behaviours. This recommendation was documented in the progress notes and also written as a physician order. Record review and interview with RPN #107 revealed the physician again recommended the intervention as the behaviours continued and could escalate. In all these instances the physician was also monitoring and altering resident #022's medications.

Interview with the DOC revealed he/she did not implement the second identified intervention as recommended by the physician because he/she did not feel there was a safety risk and the intervention might not have had the desired effect. The DOC did indicate he/she could have mentioned the home did not have the specified resources as impediments. The DOC did not feel the above mentioned first intervention would have prevented altercations as both residents gravitate towards one another. The DOC confirmed that in hindsight the second identified intervention should have been implemented and most probably would have prevented the physical altercation between resident #022 and #023.

The home failed to implement the interventions identified by the physician to minimize the risk of altercations between resident #022 and #023.

The severity of the non compliance is a potential for harm or risk. The scope is isolated to resident #022 and the home has a history of non compliance in this area issued during inspection 2015_334565_0019 November 18, 2015. [s. 54. (b)]
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The home must ensure that all residents, including resident #004, who receive nutritional supplements have the supplement evaluated for effectiveness and that the evaluation is documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Resident #004 was triggered during stage one of the RQI for an identified health condition.

Record review revealed resident #004 had the identified health condition in an identified eight-month period.

Review of the MDS assessment revealed the resident was receiving a specified diet. The resident was at risk for an identified care area. The documentation revealed the resident received a specified nutritional intervention. The care plan goal was for preventing the identified health condition.

Record review revealed that on an identified date, the RD responded to a referral related to the identified health condition and an altered skin integrity by

acknowledging the resident was receiving a specified nutritional intervention.

Record review revealed that on an identified date in the next month, the RD responded to a referral related to the identified health condition in the past month. The note revealed resident #004 was already receiving the specified nutritional intervention. No changes to the plan of care were recommended.

Record review revealed the resident continued to have the identified health condition on an identified date in the following month.

Review of the medication administration record (MARs) for three identified months revealed the nutritional intervention, although included on the MARs, was not documented as ever having been received.

Interviews with RPN #107 confirmed resident #004 was not receiving the nutritional intervention. Review of the physician's order with RPN #107 revealed the nutritional intervention was originally ordered on an identified date, however there was no evidence that it had ever been provided as it had been inaccurately processed.

An interview with the RD identified an unawareness that the nutritional intervention had not been provided to resident #004 since ordered. An interview with the DOC confirmed that the resident never received the nutritional intervention since originally ordered by the physician, and no one assessed the documented administration and/or acceptance of the nutritional intervention which would have revealed that it was never provided.

The home has failed to ensure that the nutritional intervention was evaluated for effectiveness when resident #004 was reassessed for continuously having the identified health condition.

The severity of the non compliance is actual harm or risk. The scope is isolated to resident #004 and the home has no history of non compliance in this area. [s. 6. (10) (c)]
(110)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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