Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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

Central West Service Area Office
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2019	2019_545147_0007 (A2)	012215-19, 012216-19, 012217-19, 012222-19, 012223-19, 012226-19, 012230-19	Follow up

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 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

Amended by LALEH NEWELL (147) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 24th day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Amended by LALEH NEWELL (147) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 16, 17, 18, 19, 23, 24 and 25, 2019.

The following intakes were completed in this follow-up inspection:

Log # 012216-19 - Compliance Order (CO) #002 from Inspection # 2019_773155_0007 related to plan of care being provided to the resident as specified in the plan;

Log # 012216-19 - CO #003 from Inspection # 2019_773155_0007 related to plan of care being revised because care set out in the plan had not been effective;

Log # 012217-19 - CO #004 from Inspection # 2019_773155_0007 related to having a registered nurse on duty and present at all times;

Log # 012222-19 - CO #009 from Inspection # 2019_773155_0007 related to resident-staff communication and response system;

Log # 012223-19 - CO #010 from Inspection # 2019_773155_0007 related to a 24-hour admission care plan;

Log # 012226-19 - CO #014 from Inspection # 2019_773155_0007 related to weekly reassessment of any skin and wound concerns;

Log # 012230-19 - CO #018 from Inspection # 2019_773155_0007 related to Administrator hours.

During the course of the inspection, the inspector(s) spoke with Acting Executive Director, Clinical Care Partner, Director of Care (DOC), Assistant Director of Cares, Office Manager, Scheduling Coordinator, Corporate Clinical Care Support, Director of Programs, Director of Dietary Services, Director of Quality and Informatics, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Care Support Assistants, Maintenance Aide, family members and residents.

During this inspection, inspector(s) toured resident care areas; observed meal service; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, home's investigation notes; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #009	2019_773155_0007	147
O.Reg 79/10 s. 212. (1)	CO #018	2019_773155_0007	155
O.Reg 79/10 s. 24. (2)	CO #010	2019_773155_0007	532
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #004	2019_773155_0007	155

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 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 failed to ensure that when resident #004 was noted to have an area of altered skin integrity that they received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

This inspection was completed as a follow-up to CO #014 from inspection #2019_773155_0007 related to weekly reassessment of any skin and wound.

Resident #004's Post Fall Incident Form completed by RN #107 stated that resident #004 had an altered skin integrity.

RN #107 shared that there should have been a skin and wound assessment done for the noted area but that one was not done.

ADOC #101 and ADOC #108 stated that a Head to Toe Assessment should have been done for resident #004's skin alteration but review of the Point Click Care assessments showed that no assessment was done.

The licensee failed to ensure that when resident #004 was noted to have an area of altered skin integrity that they received 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. [s. 50. (2) (b) (i)]

2. The licensee 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) The clinical records for resident #011 were reviewed and there was no weekly skin assessment completed for their areas of altered skin integrity for three weeks.

RN #107 stated that they were aware and actively treating resident #011's skin alteration. Observation made with RN #107 on a specific date in July 2019, of the resident's skin revealed that the resident had other areas of altered skin integrity in different stages of healing.

RN #107 and ADOC #108 stated that after any new skin issue was identified, registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. They reviewed the weekly skin assessments for resident #011 and acknowledged that the registered staff did not complete any weekly skin assessments related to the resident's skin alterations after the initial assessment was completed by the registered staff.

The licensee failed to ensure that resident #006 had a weekly skin assessment done by a member of the registered nursing staff.

B) On a specific date in July 2019, resident #006 had an order for follow up care related to their injuries to be completed after several days.

Review of the Point Click Care Skin and Wound Care Assessments showed that an assessment was completed for the injuries.

During an interview with ADOC #108 and ADOC #101 they shared that a weekly Skin and Wound Care Assessment should have been done, but acknowledged it was not done.

ADOC #108 shared that they worked as the registered nurse and observed that resident #006 still had their follow up care not completed. ADOC #108 shared that they completed the care and completed the Skin and Wound Care Assessment.

On two specific dates in July 2019, resident #006 was observed with a specific dressing. Record review showed that there were no further Skin and Wound Care Assessments done for resident #006 after the initial skin and wound assessment. ADOC #108 was not able to identify who applied the dressing as there was no documentation of an assessment done for resident #006.

The licensee failed to ensure that resident #006 had a weekly skin assessment done by a member of the registered nursing staff, for their skin alteration. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

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. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

This inspection was completed as a follow up to CO #010 from inspection 2019_773155_0007 related to the 24-hour admission care plan.

A) Plan of care related to fall prevention for resident #001 stated that they were at high risk of falls and interventions related to falls prevention were in place.

Observation of the resident related to fall risk showed that the resident was noted to not have specific fall preventions strategies in place. A staff member was in the room assisting a co-resident and shortly after they left the room without providing any assistance to resident #001 as specified in the resident's plan of care. The resident was then observed getting up without the use of their fall prevention interventions.

RPN #106 was called to the room by Inspector #532 to assist the resident. The RPN acknowledged that the mobility aide should be close to the resident and that one person should assist the resident related to risk of falls. The RPN did not assist the resident with their falls preventions interventions or remind the resident to use their mobility aide and said to Inspector #532 that the resident was "always like that" and walked out.

Inspector #532 left the room to look for a staff and asked PSW #115 to assist the resident as per plan of care, who assisted the resident. Later, RPN #106 returned to the room with an updated logo and placed it over the bed.

The licensee has failed to ensure that fall prevention interventions were implemented for resident #001 as outlined in the plan of care. (532)

B) Plan of care for falls prevention was reviewed for resident #032. It indicated that they were at high risk for falls and specific falls prevention interventions where in place which also included injury prevention interventions strategies.

Observation indicated that resident #032 was in bed and the falls and injury prevention strategies where not in place.

DOC # 130 confirmed that all interventions stated in the care plan were not in place for the resident.

The license has failed to ensure that the care set out in the plan of care was provided to the resident related to falls and injury prevention as specified in the plan. (155)

C) Resident #005's care plan stated that they were at high risk for falls related to actual falls and specific falls and injury prevention where in place for resident #005.

On a specific date in July 2019, resident #005 was observed in bed with the falls preventions device not functioning.

Maintenance Aide #109 changed the batteries in resident #005's device.

DOC #130 acknowledged that resident #005's device was not functioning and that it was not positioned properly under the resident.

The licensee failed to ensure that the care set out in the plan of care was provide to resident #005 as specified in the plan. (155)

D) Resident #004's care plan stated that they were at high risk for falls as they were unaware of their safety needs and included their falls preventions strategies and interventions.

On a specific date in July 2019, resident #004 was observed in bed and falls interventions were not in place.

PSW #104 and #122 and ADOC #101 shared that resident #004 was to have these falls interventions in place when in bed.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. (155)

E) Resident #006's care plan stated that they were at high risk for falls due to gait/balance problems and diagnosis and falls injury preventions were in place. for resident #006.

On a specific date in July 2019, resident #006 was observed lying in a roommate's bed and a falls intervention device was not attached to the resident. PSW #116 acknowledged that resident #006 was in the wrong bed and that the device was not attached.

On another specific date in July 2019, resident #006 was observed self-transferring into their bed from their wheelchair and their device activated. PSW #123 responded and assisted the resident, reapplied the device and implemented falls intervention strategies.

On a different date in July 2019, resident #006 was observed in bed with their device not attached, and other falls interventions were not in place.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

F) On a specific date in July 2019, resident #006 had a fall and order for follow up care related to their injuries to be completed after several days.

Review of resident #006's clinical records was done and there was no mention as to the specific follow up care that was required.

During an interview with ADOC #109 they shared they observed resident #006 still had their injury in place and directed a registered nurse to completed the care as required. ADOC #109 shared that they observed that resident #006 still had not received the follow up care to their injury and they personally completed them.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan. (155) [s. 6. (7)]

2. The licensee failed to ensure that the resident was 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 changed or care set out in the plan was no longer necessary.

Resident #005's plan of care stated that staff were to assist and prompt resident #005 to a standing position prior to walking them.

On a specific date in July 2019, resident #005 was observed to be wheeled in a wheelchair pushed by PSW #105.

PSWs #105 and #122 shared that resident #005 has not been able to walk since their last fall due to pain.

ADOC #101 acknowledged that they were aware that resident #005 was not able to walk as stated in their plan of care.

The licensee failed to ensure that resident #005's plan of care was revised when their care needs changed after their fall. (155) [s. 6. (10) (b)]

3. The licensee has failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

A) Review of resident #005's clinical records show that the resident fell on a

specific date in July 2019. Resident #005 was complaining of pain in their lower extremities when being assessed by RN #117.

Review of resident #005's care plan stated that they were often incontinent and would sometimes try to transfer independently.

PSW #105 shared that since resident #005 fell they occasionally asked for help for toileting and toiled the resident when they first got up in the morning, before meals and before going to bed. They shared that when they did this, resident #005 did not tend to self ambulate.

Associate Director of Care #101 was asked if different approaches to toileting were considered since resident #005's fall in July 2019. ADOC #101 shared that different approaches had not been added to the plan of care to minimize the risk of resident #005 self ambulating.

B) Review of resident #004's clinical records showed that resident #004 had falls on several specific dates in June and July 2019.

There was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care. Resident #004's written plan of care did not identify any new approaches or fall prevention interventions that were considered during the specified period of time.

ADOC #101 stated that different approaches were not considered for resident #004 when the falls prevention interventions in place were ineffective.

C) Review of resident #006's clinical records showed that resident #006 fell on three specific dates in July 2019. After the initial fall, ADOC #101 added additional falls intervention strategies to resident #006's plan of care.

The resident was re-assessed after subsequent falls but there was no documentation to indicate that different fall prevention interventions was considered in the revision of the plan of care. The resident's written plan of care did not identify any new approaches or fall prevention interventions that were considered and tried.

Resident #006 had a fall and was sent to hospital for further treatment of their injuries.

ADOC #101 acknowledged that resident #006 continued to experience falls and stated new interventions had not been added to the plan of care when the strategies had been ineffective.

The licensee has failed to ensure that when residents #004, #005 and #006 were reassessed and their plans of care were revised because care set out in the plans had not been effective, different approaches had been considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 002,003

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's health conditions including pain.

On a specific date in July 2019 resident #005 had a fall. At the time of the fall, they expressed that they had pain to their lower extremities when being assessed by RN #117. Resident #005 had an order for pain medication when needed and this was administered twice on three different dates in July 2019.

The doctor ordered a diagnostic test and the results showed that resident #005 had sustained an injury and further increase of pain medication was ordered by the doctor.

A pain assessment completed showed that resident #005 had pain that was occurring daily, the assessment also showed that alternative pain techniques would be used.

Another pain assessment showed that additional non-pharmacological interventions were being used to help manage pain.

Review of the care plan for resident #005 identified that it did not include that resident #005 had pain or the injury sustained as a result of the fall. The non-pharmacological interventions listed in the pain assessments were not included on the care plan or in the electronic treatment administration record (eTAR).

PSW #122 shared that they refer to Point of Care and the kardex to get direction for the care that they are to provide to residents.

During interviews with ADOC #101 and ADOC #108 they shared that pain related to the injury should have been included on the care plan along with the interventions. ADOC #101 also shared that the non-pharmacological should have been included in the eTAR.

The licensee failed to ensure that that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's health conditions including pain. [s. 26. (3) 10.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including pain, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that supplies for the falls prevention and management program were readily available at the home.

On a specific date in July 2019, resident #005 was in bed and it was observed that the specific fall prevention device was not working.

PSW #105 and RN #106 shared with the Inspector that they had to get the maintenance aide to change the batteries as they did not have access to batteries or a screwdriver that were required.

On July 19, 2019, resident #006's device unit was not functioning. DOC #127 shared that they would replace the device but, they did not have another device and they were ordering more. They shared that resident #006 would use a different device when in bed.

On two specific dates in July 2019, resident #005 was observed to have a device in use when in their wheelchair and resident #006 was using a similar device when in their wheelchair or in bed.

ADOC #101 shared that resident #005 must have been switched to a different device on their wheelchair because the other device was not working. They also shared that resident #006 still had a device when in bed. They stated that they had many of the devices in stock but DOC #127 did not know where they were kept. ADOC #101 shared they have to talk to the Physiotherapist to get the device for resident #005 and #006.

The licensee failed to ensure that supplies for the falls prevention and management program were readily available at the home. [s. 49. (3)]

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 ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #5: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48. (1) the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy titled "Falls Prevention and Management, Policy VII-G-30.10 dated April 2019", which stated that the nurse would conduct a fall risk assessment at the following times:

-within 24 hours of move in or on return from hospital.
-as triggered by the Minimum Data Set (MDS) Resident Assessment Protocol
-A significant changing status i.e. where this was a physiological functional or cognitive change in status.

On a specific date in May 2019, resident #032 was found on the floor. The resident complained of pain.

Record review indicated that a fall risk assessment was triggered by the Minimum Data Set (MDS) assessment to be completed due the fall that occurred in May 2019. A review of fall risk assessment indicated that it was not done.

ADOC #101 acknowledged that the fall risk assessment was triggered by the MDS was to be completed by the registered staff, but it was not done.

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 policy, the policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 24th day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LALEH NEWELL (147) - (A2)
Inspection No. / No de l'inspection :	2019_545147_0007 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012215-19, 012216-19, 012217-19, 012222-19, 012223-19, 012226-19, 012230-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 24, 2019(A2)
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, 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 :	Debbie Fleming

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #014;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s.50(2)(b)(i) and (iv) of O. Reg 79/10.

Specifically, the licensee must:

a) Ensure that all residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

b) Ensure that resident #004, #011 and any other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

c) Provide education to all registered staff specifically related to the different clinical tools available in the home for skin and wound assessment, when each is to be utilized and the process for completing the assessments for any resident exhibiting skin alterations. The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #014 from inspection 2019_773155_0007(A1) issued on June 19, 2019, with a compliance due date of June 21, 2019.

The licensee was ordered to be compliant with s.50(2)(b)(i) and (iv) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that all residents that exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

b) Ensure that resident #005, #011 and all residents exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

c) Ensure that an auditing process is developed and fully implemented to ensure that residents with impaired skin integrity are being assessed as provided for in the regulation. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

The licensee failed to complete steps a) and b). The licensee failed to comply with s.50(2)(b)(i) and (iv) of O. Reg 79/10.

1. The licensee failed to ensure that when resident #004 was noted to have an area of altered skin integrity that they received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

This inspection was completed as a follow-up to CO #014 from inspection #2019_773155_0007 related to weekly reassessment of any skin and wound.

Resident #004's Post Fall Incident Form completed by RN #107 stated that resident #004 had an altered skin integrity.

RN #107 shared that there should have been a skin and wound assessment done for the noted area but that one was not done.

ADOC #101 and ADOC #108 stated that a Head to Toe Assessment should have been done for resident #004's skin alteration but review of the Point Click Care assessments showed that no assessment was done.

The licensee failed to ensure that when resident #004 was noted to have an area of altered skin integrity that they received 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. [s. 50. (2) (b) (i)] (155)

2. The licensee 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) The clinical records for resident #011 were reviewed and there was no weekly skin assessment completed for their areas of altered skin integrity for three weeks.

RN #107 stated that they were aware and actively treating resident #011's skin alteration. Observation made with RN #107 on a specific date in July 2019, of the resident's skin revealed that the resident had other areas of altered skin integrity in different stages of healing.

RN #107 and ADOC #108 stated that after any new skin issue was identified, registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. They reviewed the weekly skin assessments for resident #011 and acknowledged that the registered staff did not complete any weekly skin assessments related to the resident's skin alterations after the initial assessment was completed by the registered staff.

The licensee failed to ensure that resident #006 had a weekly skin assessment done by a member of the registered nursing staff.

B) On a specific date in July 2019, resident #006 had an order for follow up care related to their injuries to be completed after several days.

Review of the Point Click Care Skin and Wound Care Assessments showed that an assessment was completed for the injuries.

During an interview with ADOC #108 and ADOC #101 they shared that a weekly Skin and Wound Care Assessment should have been done, but acknowledged it was not done.

ADOC #108 shared that they worked as the registered nurse and observed that resident #006 still had their follow up care not completed. ADOC #108 shared that they completed the care and completed the Skin and Wound Care Assessment.

On two specific dates in July 2019, resident #006 was observed with a specific dressing. Record review showed that there were no further Skin and Wound Care Assessments done for resident #006 after the initial skin and wound assessment.

ADOC #108 was not able to identify who applied the dressing as there was no documentation of an assessment done for resident #006.

The licensee failed to ensure that resident #006 had a weekly skin assessment done by a member of the registered nursing staff, for their skin alteration. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents.
The scope of the issue was a level 3 as it related to three of four residents reviewed.
The home had a level 4 compliance history that included:
Voluntary Plan of Correction (VPC) issued November 24, 2017 (2017_641513_0014) (147)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the care set out in the plan of care related to falls prevention is provided to resident #001, #004, #005, #006 and #032 and any other resident in the home, as specified in their plan.

b) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls is being provided to the residents as specified in their plans. This auditing process must be documented and include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The audit shall be kept available in the home.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #002 from inspection #2019_773155_0007(A1) issued on June 19, 2019, with a compliance due date of July 4, 2019.

The licensee was ordered to be compliant with s.6(7) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the care set out in the plan of care related to falls prevention is provided to resident #005, #032 and any other resident in the home, as specified in their plan.

b) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls is being provided to the residents as specified in their plans. This auditing process must be documented and include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The audit shall be kept available in the home.

The licensee failed to complete steps a) and b). The licensee failed to comply with s.6(7) of the LTCHA.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

This inspection was completed as a follow up to CO #010 from inspection 2019_773155_0007 related to the 24-hour admission care plan.

A) Plan of care related to fall prevention for resident #001 stated that they were at high risk of falls and interventions related to falls prevention were in place.

Observation of the resident related to fall risk showed that the resident was noted to not have specific fall preventions strategies in place. A staff member was in the room assisting a co-resident and shortly after they left the room without providing any assistance to resident #001 as specified in the resident's plan of care. The resident was then observed getting up without the use of their fall prevention interventions.

RPN #106 was called to the room by Inspector #532 to assist the resident. The RPN acknowledged that the mobility aide should be close to the resident and that one person should assist the resident related to risk of falls. The RPN did not assist the resident with their falls preventions interventions or remind the resident to use their mobility aide and said to Inspector #532 that the resident was “always like that” and walked out.

Inspector #532 left the room to look for a staff and asked PSW #115 to assist the resident as per plan of care, who assisted the resident. Later, RPN #106 returned to the room with an updated logo and placed it over the bed.

The licensee has failed to ensure that fall prevention interventions were implemented for resident #001 as outlined in the plan of care. (532)

B) Plan of care for falls prevention was reviewed for resident #032. It indicated that they were at high risk for falls and specific falls prevention interventions where in place which also included injury prevention interventions strategies.

Observation indicated that resident #032 was in bed and the falls and injury prevention strategies where not in place.

DOC # 130 confirmed that all interventions stated in the care plan were not in place for the resident.

The license has failed to ensure that the care set out in the plan of care was provided to the resident related to falls and injury prevention as specified in the plan. (155)

C) Resident #005's care plan stated that they were at high risk for falls related to actual falls and specific falls and injury prevention where in place for resident #005.

On a specific date in July 2019, resident #005 was observed in bed with the falls preventions device not functioning.

Maintenance Aide #109 changed the batteries in resident #005's device.

DOC #130 acknowledged that resident #005's device was not functioning and that it was not positioned properly under the resident.

The licensee failed to ensure that the care set out in the plan of care was provide to resident #005 as specified in the plan. (155)

D) Resident #004's care plan stated that they were at high risk for falls as they were unaware of their safety needs and included their falls preventions strategies and

interventions.

On a specific date in July 2019, resident #004 was observed in bed and falls interventions were not in place.

PSW #104 and #122 and ADOC #101 shared that resident #004 was to have these falls interventions in place when in bed.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. (155)

E) Resident #006's care plan stated that they were at high risk for falls due to gait/balance problems and diagnosis and falls injury preventions were in place. for resident #006.

On a specific date in July 2019, resident #006 was observed lying in a roommate's bed and a falls intervention device was not attached to the resident. PSW #116 acknowledged that resident #006 was in the wrong bed and that the device was not attached.

On another specific date in July 2019, resident #006 was observed self-transferring into their bed from their wheelchair and their device activated. PSW #123 responded and assisted the resident, reapplied the device and implemented falls intervention strategies.

On a different date in July 2019, resident #006 was observed in bed with their device not attached, and other falls interventions were not in place.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

F) On a specific date in July 2019, resident #006 had a fall and order for follow up care related to their injuries to be completed after several days.

Review of resident #006's clinical records was done and there was no mention as to the specific follow up care that was required.

During an interview with ADOC #109 they shared they observed resident #006 still had their injury in place and directed a registered nurse to completed the care as required. ADOC #109 shared that they observed that resident #006 still had not received the follow up care to their injury and they personally completed them.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan. (155) [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to four of five residents reviewed. The home had a level 4 compliance history that included:
Voluntary Plan of Correction (VPC) February 22, 2017 (2017_414110_0002);
VPC November 24, 2017 (2017_641513_0014);
VPC August 28, 2018 (2018_742527_0013);
VPC August 29, 2018 (2018_742527_0012);
VPC September 11, 2018 (2018_742527_0019) and
Compliance Order (CO) June 19, 2019 (2019_773155_0007(A1)) (532)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s.6(11)(b) of the LTCHA.

Specifically, the licensee must:

a) Ensure that when resident #004, #005, #006 and any other resident falls, that different fall prevention approaches are being considered and documented in the revision of the plan of care, when care set out in the plan has not been effective.

b) Conduct a review immediately post fall to determine if the current fall interventions for the resident were in place at the time of the fall as per the plan of care. If the interventions were in place and were not effective, conduct an analysis of the fall, review and implement other potential interventions and update the plan of care. This review process shall be documented and kept available in the home.

c) Provide education to all direct care staff on falls prevention and management. The education is to include the different fall prevention alarms as well as other falls prevention equipment and interventions used in the home. All direct care staff are to be advised where the falls prevention equipment and supplies are kept and accessed in the home. The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

d) Ensure that there are registered staff and managers educated and trained on how to set-up and change batteries in the fall prevention alarms. The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #003 from inspection #2019_773155_0007(A1) issued on June 19, 2019, with a compliance due date of June 21, 2109.

The licensee was ordered to be compliant with s.6(11)(b) of the LTCHA.

Specifically, the licensee must:

a) Ensure that when resident #005, #007 and any other resident falls, that different fall prevention approaches are being considered and documented in the revision of the plan of care, when care set out in the plan has not been effective.

The licensee failed to complete step a). The licensee failed comply with s.6(11)(b) of the LTCHA.

The licensee has failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

A) Review of resident #005's clinical records show that the resident fell on a specific date in July 2019. Resident #005 was complaining of pain in their lower extremities when being assessed by RN #117.

Review of resident #005's care plan stated that they were often incontinent and would sometimes try to transfer independently.

PSW #105 shared that since resident #005 fell they occasionally asked for help for toileting and toiled the resident when they first got up in the morning, before meals and before going to bed. They shared that when they did this, resident #005 did not tend to self ambulate.

Associate Director of Care #101 was asked if different approaches to toileting were considered since resident #005's fall in July 2019. ADOC #101 shared that different approaches had not been added to the plan of care to minimize the risk of resident #005 self ambulating.

B) Review of resident #004's clinical records showed that resident #004 had falls on several specific dates in June and July 2019.

There was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care. Resident #004's written plan of care did not identify any new approaches or fall prevention interventions that were considered during the specified period of time.

ADOC #101 stated that different approaches were not considered for resident #004 when the falls prevention interventions in place were ineffective.

C) Review of resident #006's clinical records showed that resident #006 fell on three specific dates in July 2019. After the initial fall, ADOC #101 added additional falls intervention strategies to resident #006's plan of care.

The resident was re-assessed after subsequent falls but there was no documentation to indicate that different fall prevention interventions was considered in the revision of the plan of care. The resident's written plan of care did not identify any new approaches or fall prevention interventions that were considered and tried.

Resident #006 had a fall and was sent to hospital for further treatment of their injuries.

ADOC #101 acknowledged that resident #006 continued to experience falls and stated new interventions had not been added to the plan of care when the strategies had been ineffective.

The licensee has failed to ensure that when residents #004, #005 and #006 were reassessed and their plans of care were revised because care set out in the plans had not been effective, different approaches had been considered in the revision of the plan of care. [s. 6. (11) (b)]

The severity of this issue was determined to be a level 3 as there was actual risk of harm to the residents.
The scope of the issue was a level 3 as it related to three of the three residents reviewed. The home has a level 4 compliance history that includes:
Compliance Order (CO) June19, 2019 (2019_773155_0007 (A1))
(155)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
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 24th day of October, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LALEH NEWELL (147) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central West Service Area Office