Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

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

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

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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 22, 2017; | 2016_248214_0022 (A1) | 028449-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE MEADOWS OF DORCHESTER
6623 Kalar Road NIAGARA FALLS ON L2H 2T3

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

CATHY FEDIASH (214) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Please note: The Licensee and Licensee Order report were amended to include the removal of example (c) from r.8(1)(b) as the home met the requirements. The second part of example (c) was removed from r.8(1)(b) and will be issued in an "Other" Inspection report under r.49(1). The intake number for the "Other" Inspection report is: 004345-17.**

**Issued on this 22 day of February 2017 (A1)**

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

**Original report signed by the inspector.**

Ontario

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

CATHY FEDIASH (214) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): September 29, 30, October 4, 5, 6, 11, 12, 13, 2016.**

**Please note: The following inspections were conducted simultaneously with this RQI:**

**-Critical Incident System Inspection 015329-15 related to: Falls**

**-Critical Incident System Inspection 007889-16 related to: Falls**

**-Complaint Inspection 004155-16 related to: Admission refusal**

**-Complaint Inspection 026517-16 related to: Resident discharge**

**-Complaint Inspection 026540-16 related to: Assessment of a resident**

**During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Associate Director of Resident Care (ADRC); Clinical Documentation and Informatics (CDI) Lead; registered staff; Personal Support Workers (PSW); Physiotherapist (PT); rehabilitation worker; President of Residents' Council; Physician and residents and families. During the course of this inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed Critical Incident System (CIS) submissions and observed the administration of medications.**

**The following Inspection Protocols were used during this inspection:**

**Admission and Discharge**

**Continence Care and Bowel Management**

**Falls Prevention**

**Family Council**

**Hospitalization and Change in Condition**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Residents' Council**

**Skin and Wound Care**

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

- **11 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 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 :**

(A1)
1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A) A review of a CIS that was submitted by the home indicated that resident #113 sustained a fall on an identified date in 2015, which resulted in injury.

A review of the resident's clinical record indicated that the resident had sustained a prior fall in 2015, which resulted in an injury. The post fall assessment and progress note that was completed on the day of the first fall in 2015, indicated that interventions were to refer the resident to Occupational Therapy and Physiotherapy (OT/PT) and that this had been completed. A review of the resident's clinical record indicated that no assessment from either OT or PT could be located. An interview with staff #012, a rehabilitation worker and with the Physiotherapist, confirmed that an assessment had not been completed as a referral had not been received.

A review of the home's policy titled, "Referral to Physiotherapy and Occupational Therapy (PCS06-004 with a reviewed and revised date of October 17, 2014) indicated the following:

i) Staff will initiate referral by documenting in the electronic chart under the progress note "Referral Progress Note" completing all sections as outlined.

ii) Staff will notify appropriate department by going to senior services icon-Referrals Notification and complete the OT/PT referral.

An interview with the ADRC confirmed that a referral to OT/PT had not been completed in the home's Point Click Care (PCC) "referral progress note" as well as a referral had not been completed in the senior services referral system which is known as "Sherpa". The ADRC confirmed that the home had not complied with their referral policy.

This non-compliance was issued as a result of the following CIS inspection #015329-15. (Inspector #214)

B) The Weight Monitoring Policy, Index No: RS00-015, revised April 1, 2016, directed the RN/RPN to supervise the completion of the monthly weights. If the weight change triggered a significant weight change in PCC, then a reweigh should be done.

i) The Weights and Vitals Summary for resident #108, identified a weight loss over a one month period in 2016 and later a weight gain over a one month period in 2016.

There were no reweighs done when the significant weight changes were recorded. The DRC confirmed the reweighs were not completed and that the Weight Monitoring Policy, Index No: RS00-015, revised April 1, 2016, was not complied with. (Inspector #130).

ii) The Weights and Vitals Summary for resident #103, identified a significant weight loss over a one month period and a significant weight gain over a different one month period.

There were no reweighs done when the significant weight changes were recorded. The DRC confirmed the reweighs were not completed and that the Weight Monitoring Policy, Index No: RS00-015, revised April 1, 2016, was not complied with. (Inspector #130).

***Additional Required Actions:***

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

**(A1)The following order(s) have been rescinded:CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure that residents were not neglected by the licensee or staff. Interviews conducted with registered staff #010, #063, #042 and #001, PSW staff #076, #121 and resident #110's Substitute Decision Maker (SDM) revealed that on an identified date in 2016, the resident started exhibiting abnormal symptoms. Progress notes indicated that registered staff #042 examined the resident and determined the resident required an intervention. Registered staff #042 implemented the intervention, in accordance with a doctor's order. The resident was reassessed a short time later and it was noted that the intervention had been slightly effective in improving their symptoms. The resident's SDM had requested that the resident remain in bed, resting until assessment findings showed the resident's status improved.

A progress note recorded later that day said that after the SDM left the home, registered staff #063 reassessed the resident and performed a treatment to determine if their status had worsened or improved and that they recorded that one of their symptoms had worsened, despite a treatment intervention and that their colour was normal and the resident was calm. The same progress note revealed staff got the resident up because the resident was trying to get out of bed. Registered staff #063 confirmed in an interview that the resident was restless and trying to get out of bed. They said the resident was an identified fall risk and was at risk of falling, if left in bed over the dinner hour, when staff would be assisting in the dining room. Registered staff #063 reported the resident's condition to registered staff #010 and requested direction whether to leave the resident in bed over the dinner hour. Registered staff #063 said registered staff #010 instructed them to bring the resident to the dining room for dinner, despite the earlier request from the SDM, to leave the resident in bed until their condition improved. Registered staff #063 confirmed the resident was taken to the dining room at approximately 1700 hours and remained there until approximately 1800 hours. Registered staff confirmed there were no further assessments of the resident performed prior to taking the resident to the dining room. Registered staff #063 and registered staff

#010 confirmed there was no treatment provided to the resident in the dining room.

Registered staff #063 stated that at 1800 hours, PSW's informed them that the resident was again exhibiting abnormal symptoms. Registered staff #063 said that they instructed the PSWs to take the resident back to their room and initiate a treatment. Registered staff #063 documented the resident did not eat dinner and returned to bed at 1800 and received a treatment. Registered staff #063 confirmed in an interview that they did not assess the resident at that time and not until they were summoned to the resident's room at 1840 hours by PSW #121, who reported the resident was exhibiting worsening symptoms. Registered staff #063 recorded at 1906 hours that the resident was having worsening symptoms. Assessment findings confirmed worsening status and shortly after returning to their room, the resident had a change in status.
The resident's attending physician confirmed in an interview that they were not informed of the resident's deteriorating condition until after the resident had a change in status. Registered staff #063 confirmed an intervention was not initiated; the attending physician was not notified and that 911 was not called.

Registered staff #010 said in an interview on a specified date in 2016, that when the resident's health condition declined, they did not check the resident's chart to confirm what action was to be taken. Registered staff #010 confirmed that attempts were made to call the SDM and another family member, before the resident change in status. This was confirmed in a progress note on a specified date in 2016 at 1843 hours.

On an identified date in 2016, resident #110 was neglected by staff when staff did not provide resident #110 with a treatment to relieve abnormal symptoms for approximately one hour despite exhibiting a number of abnormal symptoms; registered staff neglected to assess the resident for approximately 40 minutes between 1800 and 1840 hours, despite reports from PSWs that the resident was exhibiting abnormal symptoms; there was no recorded assessment of a specified vital sign since 1548 hours; no recorded assessment of another specified vital sign since 1611 hours and no recorded assessment of a third vital sign since 1645 hours and no evidence found that the resident had any other assessment done during this time period. The physician was not notified of the change in the resident's condition, which began at approximately 1300 hours; 911 was not called and an intervention was not initiated when there was a change in the resident's status, despite a request by the SDM.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 19. (1)] (130) [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A review of a CIS that was submitted by the home indicated that on a specified

date in 2016, resident #114 sustained a fall during care that resulted in an injury.

A review of the resident's written plan of care in place over a nine month period in 2016, indicated that their plan had not contained any information regarding the resident's preference for a specific type task or the level of assistance nor the number of staff required to complete the task. During an interview with the resident in 2016, they confirmed their preferred method of the task.

An interview with the DRC confirmed that the planned care for the resident had not been included in the resident's written plan of care.

This non-compliance was issued as a result of CIS inspection #007889-16, which was conducted concurrently with the RQI. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

At the time of resident #110's admission in 2013, the resident's SDM provided directions to staff regarding care.

On a specified date in 2015, registered staff #016, hand-wrote a directive which was contrary to the previously identified wishes of the SDM. On another identified date in 2015, the same staff changed the "profile" tab in PCC, which provided direction to the staff, which was contrary to the directive signed by the SDM.

A progress note dated on a different date in 2015, indicated there had been a discussion with the SDM regarding the resident's treatment wishes. The nurse recorded that verbal consent had been obtained from the SDM to change their previously stated treatment wishes. A second progress note dated in 2015, indicated a discussion had been held with the SDM about receiving identified interventions versus not and that the "POA" had stated they did not wish the resident to go to hospital under any circumstances. The note indicated the "POA" had given verbal consent for the resident to change their treatment wishes and that the nurse had updated the form.

The Administrator and the DRC confirmed that registered staff #016, did not void the original directives form and did not ensure that a new form was signed by the SDM. The Administrator and the DRC also confirmed that the form was not reviewed and signed by the SDM at the Interdisciplinary Care conference held in

2015, as per the home's policy, thus rendering the form invalid.

Registered staff #010 confirmed that 911 was not called and staff did not provide an intervention.

It was confirmed that the plan of care did not provide clear directions to staff regarding the resident's treatment wishes.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A Hendrich Falls Risk assessment completed for resident #110, on an identified date in 2015, identified the resident's need for a safety device. On an identified date in 2015, the DRC confirmed the written plan of care did not include the need for a safety device until some time later in 2015.

The plan of care was not based on the assessed needs of the resident.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

According to the clinical record, resident #110, sustained falls on six occasions over a four month period in 2015. The Hendrich fall risk assessments completed on an identified date in 2014 and 2015, identified the resident was at high risk for falls; however, the post fall assessments completed on three other occasions during the same time period identified the resident was at moderate risk for falls. The DRC confirmed the post fall assessments completed on at least two occasions in 2015, did not reflect an accurate falls history over the previous six months, prior to the assessment. The DRC also confirmed the assessments were not collaborative in their findings.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. [s. 6. (4) (a)]

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

On an identified date in 2016, resident #110 exhibited abnormal symptoms and the resident's SDM had requested earlier in the day that the resident remain in bed to rest until their condition improved; registered staff #063 confirmed in an interview that the resident was restless and trying to get out of bed. They said the resident was an identified fall risk and was at risk of falling, if left in bed over the dinner hour, when staff would be assisting in the dining room. Registered staff #063 reported the resident's condition to registered staff #010 and requested direction whether to leave the resident in bed over the dinner hour. Registered staff #063 said registered staff #010 instructed them to bring the resident to the dining room for dinner. Registered staff #063 confirmed the resident was taken to the dining room at approximately 1700 hours and remained there until approximately1800 hours.

The resident did not have a treatment initiated when they exhibited abnormal symptoms, as prescribed for abnormal symptoms and when their symptoms warranted it while in the dining room. Registered Staff #063 confirmed that a specified treatment should have been initiated when the resident's conditioned warranted it. Care was not provided in accordance with the plan.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 6. (7)]

6. 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.

A) Staff interviews conducted during stage one of the RQI indicated that resident #107 had sustained a fall 30 days prior. A review of the resident's progress notes that were documented on a specified date in 2016, indicated that the resident was found on the floor in a co-resident's room doorway. The fall was unwitnessed. No injuries were identified at the time of the incident; however, the resident began to demonstrate an increase in an abnormal symptom the following day.

A review of the resident's written plan of care in place at the time of their fall stated under the falls focus that staff were to ensure that the resident's bed was at the assessed level. On observation of the resident's room, a green line that was to be level with the head board of the bed was unable to be found. An interview with registered staff #036, who also observed the resident's room, indicated that they were unable to locate the green line and were unaware of what the green line was related to.

An interview with the ADRC confirmed that the green line was a piece of green tape that was placed on the wall behind the head board of the bed. The green tape line was to be used as a measurement for staff to know at what height the resident's bed was to be placed at to minimize falls and injury from their bed. The ADRC confirmed that the green tape had not been in use for some time as the resident no longer made attempts to self-transfer from their bed and required the assistance of two staff to perform this task. The ADRC confirmed that the plan of care had not been reviewed and revised when the care set out in the plan was no longer necessary.

B) Resident #110 sustained a fall with injury on an identified date in 2015. A specified assessment completed on an identified date in 2015, indicated the resident has had a significant change in health status. Resident had another fall in 2015. Resident had sustained an injury; was using a wheelchair for mobility and a PASD for the promotion of independence with ADL's (activities of daily living), promotion of hydration, and distraction for activities and healing injury.

A progress note completed by the physiotherapist on an identified date in 2015, that included their observations.

The written plan of care was not updated to include the use of a specified intervention over a specified time period in 2015, despite the assessed need for the specified intervention months earlier.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 6. (10) (b)]

***Additional Required Actions:***

**CO # - 003 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 is a written plan of care for each resident that sets out the planned care for the resident; to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the plan of care is 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, to be implemented voluntarily.***

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the safety risks with respect to a resident .

A) A Significant Change in Status Assessment completed on a specified date in 2015, indicated the resident was using a wheelchair for ambulation. A Post Fall Assessment completed on another date in 2015, indicated the resident was at risk for falls and identified the need to assess for a specific safety intervention.

On an identified date in 2015, the clinical record confirmed the resident sustained a fall . The resident sustained a second fall on the same day which resulted in a serious injury.

It was confirmed by the DRC that the resident was not assessed for a specified safety intervention. (Inspector #130).

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 26. (3) 19.]

***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 plan of care is based on, at a minimum, an interdisciplinary assessment of the safety risks with respect to a resident, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A) A review of resident #101's clinical record indicated that the resident used an identified device while up in their wheelchair for prevention of injury to self. A review of the tasks in the Point of Care (POC) documentation system indicated that the resident was to be checked hourly and repositioned every two hours and as necessary when the identified device was in use. A review of this task for a specified period of three days in 2016, indicated that the identified device had been in use; however, not all of the actions of checking the resident hourly and repositioning them every two hours had been documented consistently.

An interview with PSW #055 and registered staff #106 confirmed that staff do check the resident every hour and reposition the resident every two hours when their identified device is in use; however they do not always consistently document these actions. An interview with the DRC confirmed that not all actions taken with respect to the resident's identified device had been documented.

B) During a tour of the home, resident #102 was observed to have an identified device in place while sitting in their wheelchair. A review of the resident's clinical record indicated that the identified device was used as a personal assistive services device for a specified purpose.

A review of tasks in the POC documentation system indicated that staff was to check the resident on odd hours and to reposition the resident on even hours. A review of this task for an identified period of three days in 2016, indicated that the identified device had been in use; however, not all actions of checking the resident on odd hours and repositioning the resident on even hours had been documented

consistently.

An interview with PSW staff #011 and registered staff #101 confirmed that staff do check the resident hourly and reposition the resident every two hours; however, they do not always consistently document these actions. An interview with the DRC confirmed that not all actions taken with respect to the resident's identified device had been documented.

C) Staff interviews conducted during stage one of the RQI indicated that resident #107 had sustained a fall 30 days prior. A review of the resident's progress notes that were documented on an identified date in 2016, indicated that the resident was found on the floor in a co-resident's room doorway. The fall was unwitnessed. No injuries were identified at the time of the incident; however, the resident began to demonstrate an increase in an identified symptom the following day.

A review of the resident's written plan of care indicated under the falls focus that staff was to check the resident hourly to ensure their safety. A review of the POC documentation task for hourly checks for a specified date in 2016, indicated that the resident was documented as being checked at an identified time and not again until five hours later. A review of this task for a specified period of two days in 2016, indicated that documentation for the completion of hourly safety checks had not been completed consistently.

An interview with PSW staff #121 confirmed that the resident is checked hourly; however, they do not always consistently document these actions. An interview with the ADRC confirmed that that not all actions taken with respect to the resident's hourly safety checks had been documented.

D) Registered staff #010 confirmed in an interview that they were summoned to the resident's room by staff. Registered staff #010 and registered staff #063 verified they were present in the resident's room and confirmed in an interview that the scene was "dramatic", the resident was exhibiting identified symptoms. Registered staff #063 confirmed that not all of their assessments and interventions were documented and registered staff #010 confirmed they did not document any of their observations.

Not all action's taken with respect to resident #110 on an identified date in 2016, were documented.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #110 had a physician's order for a specified treatment for a specified symptom.

According to the Medication Administration Record (MAR), on twelve occasions in 2015, the treatment was not administered as per the order.

The DRC confirmed the above information.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

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

During a tour of the home on an identified date in 2016, it was observed that the "Clean Utility" room door was unlocked on two identified units it was observed that the door was locked; however, the door closure failed to allow the door to close all of the way ensuring a locked position. In both rooms, unlocked treatment carts were observed which contained Proviodine Iodine. Hydrogen Peroxide cleaner disinfectant wipes were observed on the counter and a bottle of Arjo all- purpose disinfectant was observed in a cupboard which was accessible.

An interview with the Administrator and the DRC confirmed that the doors were to be locked and the rooms secured at all times. [s. 5.]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The written plan of care for resident #110 stated the resident required extensive assistance for transferring from one position to another, with a specified device.

Staff #121 confirmed in an interview that on an identified date in 2016, at approximately 1800 hours, they transferred the resident to bed with a co-worker, without using the specified device.

Care was not provided to resident #110 in accordance with the plan.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 36.]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home**

**Specifically failed to comply with the following:**

**s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,**
**(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).**
**(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).**
**(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that an application for admission was approved unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

On an identified date in 2016, the home provided resident #112 with a written letter indicating that their acceptance for admission had been declined because the resident's individualized needs for nutrition and hydration could not be managed by the staff in the area that the bed was available.

The reason for this refusal did not meet the grounds for withholding approval as specified in the legislation. 2007, c. 8, s. 44. (7).

Please note this non compliance was issued as a result of complaint # 004155-16, which was conducted concurrently with the RQI. [s. 44. (7)]

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

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they informed the Director immediately, in as much detail as is possible in the circumstances, of an unexpected or sudden death.

Resident #110 passed away, in the home on an identified date in 2016. Registered staff and PSW's interviewed confirmed the resident's death was sudden and unexpected. This was also confirmed in the death record. The DRC and the Administrator confirmed the Director was not notified of the sudden and unexpected death of resident #110.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 107. (1) 2.]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

On an identified date in 2016, it was observed that the discontinued controlled substances and narcotics were stored in a locked stationary cupboard within a locked medication room.

The stationary cupboard was observed to be fixed to the upper wall and contained an opening near the top of the upper cupboard to allow staff access to place the discontinued controlled substances and narcotics into. The Long Term Care Homes (LTCH) Inspector was able to reach into the opening and remove two narcotic cards.

The ADRC who was present confirmed that the stationary cupboard was not secured. [s. 129. (1) (a)]

**Issued on this 22 day of February 2017 (A1)**

**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**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** CATHY FEDIASH (214) - (A1)

**Inspection No. / No de l'inspection :** 2016_248214_0022 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** 028449-16 (A1)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Feb 22, 2017;(A1)

**Licensee / Titulaire de permis :** THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

**LTC Home / Foyer de SLD :** THE MEADOWS OF DORCHESTER
6623 Kalar Road, NIAGARA FALLS, ON, L2H-2T3

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Colleen Tufts

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 THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to comply with the following order(s) by the date(s) set out below:

**(A1)**
**The following Order has been rescinded:**

**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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

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**Order # / Ordre no :** 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall protect residents from neglect by doing the following:

1. Administer oxygen as per physicians' orders and document the residents' tolerance while in use.

2. Provide mandatory education to all direct care staff on the signs and symptoms of respiratory distress or abnormal breathing.

3. Follow residents' care plans when oxygen administration is in use.

4. Monitor residents with oxygen for signs and symptoms of respiratory distress and notify the physician as directed.

5. Review the advance directives of all residents and annually thereafter at the interdisciplinary care conference, as directed by the home's policy, Index No: PCS02-001, revised April 8, 2014 and ensure the directives are followed.

6. Complete and document any assessments in the resident's clinical record; monitor and document vital signs as directed by the home's policy.

7. Development and implementation of a system or a process to ensure that all resident or Substitute Decision Makers (SDM) requests for resident care are responded to and all actions taken are documented by the appropriate staff.

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with LTCHA, s. 19 (1) , in respect of the potential for harm that resident #110 experienced , the scope of pattern of one resident and the licensee's history of previous non-compliance with a VPC on December 2, 2014, Resident Quality Inspection related to s.19(1).

The licensee failed to ensure that residents were not neglected by the licensee or staff. Interviews conducted with registered staff #010, #063, #042 and #001, PSW staff #076, #121 and resident #110's Substitute Decision Maker (SDM) revealed that on an identified date in 2016, the resident started exhibiting abnormal symptoms. Progress notes indicated that registered staff #042 examined the resident and

determined the resident required an intervention. Registered staff #042 implemented the intervention, in accordance with a doctor's order. The resident was reassessed a short time later and it was noted that the intervention had been slightly effective in improving their symptoms. The resident’s SDM had requested that the resident remain in bed, resting until assessment findings showed the resident's status improved.

A progress note recorded later that day said that after the SDM left the home, registered staff #063 reassessed the resident and performed a treatment to determine if their status had worsened or improved and that they recorded that one of their symptoms had worsened, despite a treatment intervention and that their colour was normal and the resident was calm. The same progress note revealed staff got the resident up because the resident was trying to get out of bed. Registered staff #063 confirmed in an interview that the resident was restless and trying to get out of bed. They said the resident was an identified fall risk and was at risk of falling, if left in bed over the dinner hour, when staff would be assisting in the dining room. Registered staff #063 reported the resident’s condition to registered staff #010 and requested direction whether to leave the resident in bed over the dinner hour. Registered staff #063 said registered staff #010 instructed them to bring the resident to the dining room for dinner, despite the earlier request from the SDM, to leave the resident in bed until their condition improved. Registered staff #063 confirmed the resident was taken to the dining room at approximately 1700 hours and remained there until approximately 1800 hours. Registered staff confirmed there were no further assessments of the resident performed prior to taking the resident to the dining room. Registered staff #063 and registered staff #010 confirmed there was no treatment provided to the resident in the dining room.

Registered staff #063 stated that at 1800 hours, PSW’s informed them that the resident was again exhibiting abnormal symptoms. Registered staff #063 said that they instructed the PSWs to take the resident back to their room and initiate a treatment. Registered staff #063 documented the resident did not eat dinner and returned to bed at 1800 and received a treatment. Registered staff #063 confirmed in an interview that they did not assess the resident at that time and not until they were summoned to the resident’s room at 1840 hours by PSW #121, who reported the resident was exhibiting worsening symptoms. Registered staff #063 recorded at 1906 hours that the resident was having worsening symptoms. Assessment findings confirmed worsening status and shortly after returning to their room, the resident had a change in status.

The resident's attending physician confirmed in an interview that they were not informed of the resident's deteriorating condition until after the resident had a change in status. Registered staff #063 confirmed an intervention was not initiated; the attending physician was not notified and that 911 was not called.

Registered staff #010 said in an interview on a specified date in 2016, that when the resident's health condition declined, they did not check the resident's chart to confirm what action was to be taken. Registered staff #010 confirmed that attempts were made to call the SDM and another family member, before the resident change in status. This was confirmed in a progress note on a specified date in 2016 at 1843 hours.

On an identified date in 2016, resident #110 was neglected by staff when staff did not provide resident #110 with a treatment to relieve abnormal symptoms for approximately one hour despite exhibiting a number of abnormal symptoms; registered staff neglected to assess the resident for approximately 40 minutes between 1800 and 1840 hours, despite reports from PSWs that the resident was exhibiting abnormal symptoms; there was no recorded assessment of a specified vital sign since 1548 hours; no recorded assessment of another specified vital sign since 1611 hours and no recorded assessment of a third vital sign since 1645 hours and no evidence found that the resident had any other assessment done during this time period. The physician was not notified of the change in the resident's condition, which began at approximately 1300 hours; 911 was not called and an intervention was not initiated when there was a change in the resident's status, despite a request by the SDM.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 19. (1)] (130) [s. 19. (1)]

(130)

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

Jan 11, 2017

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

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

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

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**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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 shall ensure that care set out in the plan of care is provided to residents as specified in their plans, specifically related to the following:

1. Ensuring all residents requiring oxygen receive the required oxygen rate, as prescribed by the physician.

## 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

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with LTCHA, s.6 (7), in respect of the minimal harm or potential for actual harm that resident #110 experienced , the scope of isolated of one resident within the context of a Resident Quality Inspection and the licensee’s history of previous non -compliance with a VPC on December 2, 2014, Resident Quality Inspection's related to s.6(7).

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

On an identified date in 2016, at 1645 hours, resident #110 exhibited abnormal symptoms and the resident's SDM had requested earlier in the day that the resident remain in bed to rest until their condition improved; registered staff #063 confirmed in an interview that the resident was restless and trying to get out of bed. They said the resident was an identified fall risk and was at risk of falling, if left in bed over the dinner hour, when staff would be assisting in the dining room. Registered staff #063 reported the resident's condition to registered staff #010 and requested direction whether to leave the resident in bed over the dinner hour. Registered staff #063 said registered staff #010 instructed them to bring the resident to the dining room for dinner. Registered staff #063
confirmed the resident was taken to the dining room at approximately 1700 hours and remained there until approximately1800 hours.

The resident did not have a treatment initiated when they exhibited abnormal symptoms, as prescribed for abnormal symptoms and when their symptoms warranted it while in the dining room. Registered Staff #063 confirmed that a specified treatment should have been initiated when the resident's conditioned warranted it. Care was not provided in accordance with the plan.

This non compliance was issued as a result of complaint #026540-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 6. (7)] (130)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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 :**

Jun 23, 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

## 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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON  M5S 2B1
Télécopieur : 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 22 day of February 2017 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** CATHY FEDIASH - (A1)

**Service Area Office /**
**Bureau régional de services :** Hamilton