Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2014	2014_395151_0007	S-000433-14	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH CENTENNIAL MANOR INC.
2 Kimberly Drive, KAPUSKASING, ON, P5N-1L5

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

NORTH CENTENNIAL MANOR
2 KIMBERLY DRIVE, KAPUSKASING, ON, P5N-1L5

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

MONIQUE BERGER (151), GILLIAN CHAMBERLIN (593), JANET MCNABB (579)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 21,22,23,24,25,27,28,29,30,31, 2014

This inspection relates to SAO log number:S-000433-14 and involved Inspectors 151,579 and 593

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Director of Care
- Manager for Finance
- Food Service Supervisor

- Coordinator for Leisure and Activities
- Laundry Aide
- Maintenance Manager
- Registered Staff
- Personal Support Workers (PSW)
- President of Resident Council
- residents
- family and visitors

During the course of the inspection, the inspector(s)
- made direct observation of resident care and services
- walked-through the home daily
- reviewed resident health care records
- reviewed policies, procedures, protocols and programs in regards to the management of falls
- reviewed policies, procedures, protocols and programs in regards to the management of responsive behaviours
- reviewed policies, procedures, protocols and programs in regards to dietary services
- reviewed policies, procedures, protocols and programs in regards to continence care
- reviewed policies, procedures, protocols and programs in regards to management of trust funds
- inspected issues triggered through the resident quality inspection process

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. Inspector #579 reviewed the Home's Policy and Procedure in the Subsection of Nutrition titled "Measuring Height & Weight: RCM-11 D effective November 2004 and noted that the document stated the Dietary Department " will calculate the resident's

ideal body weight (IBW) from the admission height and weight and this will be recorded on the care plan".

Inspector 151 reviewed the home's policies and procedure titled: "Nutritition and Hydration Program"; November 1, 2012. Inspector noted a reference on page 8 of the policy program that states: " Evaluate resident's height and weight on admission, check height yearly and weight monthly".

Inspector #579 noted that in reviewing resident health care records for weights and heights of residents, it became apparent that the residents' heights were documented sporadically over varying years. Inspector #579, interviewed staff #206 who stated that it was not the home's usual practice to measure residents' heights on an annual basis. Inspector 151 reviewed the resident health care records for 13 residents and noted that only 3 of the 13 residents had a height recorded in the year 2014. Inspector #579 reviewed the Home's Policy and Procedure in the Subsection of Nutrition titled "Measuring Height & Weight: RCM-11 D effective November 2004 and noted that the document stated the Dietary Department " will calculate the resident's ideal body weight (IBW) from the admission height and weight and this will be recorded on the care plan".

The licensee has failed to ensure that there is a weight and height monitoring system to measure and record each resident's body mass and height on admission and annually thereafter

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

2. Inspector 151 observed the noon day meal and noted that only one of the posted menu entree choices was available to residents requiring texture modified puree diets. Dietary Aide and Staff #208 confirmed that the residents were only provided with one of the posted entree choices and that it was dietary staff that chose which entree would be prepared that day. Staff #208 confirmed that most of the residents who require puree diets would be able to choose if presented with visual choices of the entrees.
The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.
As such, the licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the

residents. [s. 11. (1)]

2. In an interview with Inspector 151, Staff #201 and Staff #202 confirmed that the home has been without a dietitian for the last 2 years. Staff #201 confirmed that the home did have residents with skin and wound issues, though wound rate was below provincial average. Staff#201 confirmed there has been no ability to refer residents with wound and skin integrity issues for dietary assessment, as there is no dietitian. Due to the lack of the services of a dietitian, those residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have not:
* been assessed by a registered dietitian who is a member of the staff of the home, and
* had any changes made to the plan of care related to nutrition and hydration been implemented

As such, the licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. [s. 11. (1)]

3. Inspector #579 and #151 reviewed the home's weight monitoring program policy: reference:MEASURING HEIGHTS AND WEIGHTS; POLICY NUMBER RCM-11-D - last revised November 2004. The policy states that Health Care Aides are to weigh the residents every month and " compare current readings with last month's weights and re-weigh if there is a change of 2 lbs of more" from the previous month's weight. Inspector 151 reviewed the policy with staff #203 who confirmed that the home was still following this policy.

In an interview with Inspector 151, Staff #201 stated that , in absence of a dietitian, Nursing and the Staff #208 had assumed the responsibilities of nutritional care, however, there was no written protocol in regards to this. Registered Nurses and the Staff #208 were responsible for monitoring residents' weights and were responsible for following up on weight loss/gain exception warnings generated by the home's software program in relation to each resident's percentage of weight change triggers at 1 month, 3 months and 6 months. On October 23, 2014, during the Resident Quality Inspection, the Staff #201 submitted to Inspector 151 a draft referenced: NUTRITION AND HYDRATION; PROCEDURE TO FOLLOW IN ABSENCE OF DIETITIAN. Staff #201 confirmed that this document represented what the licensee had been doing since the loss of the dietitian in regards to the nutrition and hydration care of residents.

Inspector reviewed the weight history for 2 residents and noted 3 incidents where residents weight differed significantly from previous month's weight. In regards to the weight variations, there was no indication that the residents were subjected to re-weigh as per the home's policy as the next recorded weight is for the following month.

Inspector 579 reviewed the document; WEIGHTS AND VITALS SUMMARY for all residents and for the dates range of July 30, 2014 to October 30, 2014 and noted multiple residents who had not had re-weighs entered for significant changes within 1 month or 3 months and for whom the home's software program documented exception alerts in regards to these weight variations. No documented re-weighs were entered for any of these exceptions

The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated:
a. A change of 5 per cent of body weight, or more, over one month
b. A change of 7.5 per cent of body weight, or more, over three months
c. A change of 10 per cent of body weight, or more, over 6 months
d. Any other weight change that compromises their health status

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. [s. 11. (1)]

4. In an interview with the Inspectors, Staff #201 and Staff #202 confirmed the home has been without a dietitian for the last 2 years. Through Inspector 151's review of residents' health care records and Inspector 579's review of the last 3 months of resident weight histories, Inspectors noted the home is not following their re-weigh policies when weights taken have a 2.5 pound difference. Inspector's noted examples where software generated triggered weight warnings went as long as 3 months before being addressed and/or corrected. Inspectors 151 and 579 noted that in reviewing resident health care records, residents were not being measured for height on an annual basis as per the home's policy: this having influence on the accuracy of BMI calculations

In an interview with Inspector 151, both the Staff #201 and Staff # 206 confirmed that the residents' weights and attention to software generated warnings of weight changes

have not been consistently monitored and assessed. Both the Staff #201 and Staff #206 confirmed that the home's draft plan "Procedure to Follow in Abscence of Dietitian" has not always been followed.

Because there has been no registered dietitian at the home for the last 2 years, the requirements for the registered dietitian who is a member of the staff of the home to do the following has not been met:
(a) complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition; and
(b) assess the resident's
- nutritional status, including height, weight and any risks related to nutrition care, and
- hydration status, and any risks related to hydration

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. [s. 11. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

s. 241. (5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,
(a) a system to record the written authorizations required under subsection (8); and O. Reg. 79/10, s. 241 (5).
(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money. O. Reg. 79/10, s. 241 (5).

s. 241. (6) The licensee shall provide a copy of the written policy and procedures to every resident and person acting on behalf of a resident who asks to have money deposited into a trust account. O. Reg. 79/10, s. 241 (6).

s. 241. (7) The licensee shall,
(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. In an interview with the Inspector 151, Staff # 207 confirmed that the home held trust funds for 77 of their 78 residents. Manager confirmed that funds entrusted to the home on behalf of a resident [Trust Funds] were held in an interest bearing account with the local financial institution.

Inspector 151 reviewed the statement of account for the month of September 2014 from the financial institution where the deposits for the trust funds are held and noted that the account did have interest money paid to it. Manager of Finance stated that he did not know where in the home's finance system this interest was being credited to.

The licensee did not establish and maintain one non-interest bearing trust account at a financial institution for depositing money entrusted to the licensee's care on behalf of a resident [s. 241. (1)]

2. In an interview with Inspector 151, Staff # 207 confirmed that the home does not have written policies and procedures for the management of trust accounts.

The licensee has failed to ensure that there are policies and procedures for the management of trust accounts and the petty cash trust money that include:
(a) a system to record written authorizations, and
(b) the hours when the resident or persons acting on behalf of the resident can make deposits or withdrawals from the funds in a trust account and from petty cash trust money [s. 241. (5)]

3. In an interview with Inspector 151, Staff #207 confirmed that the home does not have written policies and procedures for the management of trust accounts and as a result, no resident or their representative have written information on the home's current process in the management of trust accounts.
The licensee has failed to ensure that the policy and procedures for the management of trust accounts and petty cash trust money have been provided to every resident and person acting on behalf of a resident who asks to have money deposited into a trust account [s. 241. (6)]

4. In an interview with Inspector 151, Staff # 207 confirmed that unless a resident or their representative specifically requests it, no receipt is provided for money deposited into a trust account.

The licensee has failed to ensure that a receipt is provided to the resident for money deposited into a trust account. [s. 241. (7) (a)]

5. In an interview with Inspector 151, Staff # 207 confirmed that unless a resident or their authorized representative specifically requests it, no quarterly statements are

provided. Only 2 residents of the 77 who have funds held in trust by the home have requested and are receiving quarterly statements.

The licensee has failed to ensure that itemized statements provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident, that include:

* deposits
* withdrawals, and
* the balance of the resident's funds as of the date of the statement [s. 241. (7) (f)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. Inspector #579 reviewed resident #003's health care record and care plan and noted an intervention on the care plan stating that the resident is allowed special leave. In an interview with Inspector #579, staff #203 stated that the resident was no longer capable of this and that the activity had not occurred for some time. Inspector noted that the reference in the care plan was dated as being initiated in 2010 and that as of September 25, 2014, the issue was deemed to still be current. In an interview with Inspector #579, staff #205 confirmed that the resident is no longer capable of this care plan consideration.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #579 observed resident #006 and resident #007 who had been placed in infection control isolation. The posted directions indicated that the residents were to eat in their rooms and that staff and visitors were to wear personal protective equipment of masks and gloves. Inspector #579 observed both rooms had signage warning visitors and staff to wear Personal Protective Equipment (PPE) and both of these residents had an alcohol hand wash station immediately outside their bedroom door.

Inspector #579 reviewed both of the residents' care plans and could find no reference for the need for isolation precautions or the need for residents to eat in their room. Inspector reviewed both of the residents' kardex summaries of the care of plans and could find no reference to the need for isolation precautions or the need for residents to eat in their rooms

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector #593 reviewed resident #020's plan of care and noted, that in regards to toileting, staff were directed to do one person constant supervision and physical assistance for safety due to cognitive deficits and impaired mobility. The care plan directed that the resident was to be toileted at regular intervals to match the resident's voiding habits and promote continence and this includes: upon rising, 10:00, 12:30, 14:00, 17:30, 19:00 and at HS. The plan of care directs staff to prompt the resident to void on a scheduled basis and this includes: 07:00, 09:00, 11:00, 13:00, 15:00, 17:00 and before bed.

Inspector noted the pink communication card above resident #020's bed indicated that the resident was a one person assist for toileting. Inspector reviewed the resident's plan of care and noted the plan was consistent in directing staff to provide one person constant assist and supervision for toileting and to prompt for toileting.

A review of the homes Continence Care and Bowel Management Program; implemented February 2011, found that PSWs are required to follow the resident's individual plan of care for continence care interventions.

During separate interviews with Inspector #593, PSW staff members #214, 215, 216, 217 and 218 all confirmed that resident #020 does not require any assistance from staff with toileting as the resident is totally independent with this task, resident knows when to do this and does not need prompting by staff to toilet.

Inspector 593 made multiple observations of resident # 020.
- October 29, 2014, for the period of 14:00 and 14:30, there was no attempt made by staff to assist the resident in toileting. During this time, the resident was seated in the room watching TV. At no time during this observation period did the resident toilet self.
- On October 30, 2014 between the hours of 09:45 and 10:20 Inspector 593 observed the resident to be seated in the bedroom the entire time and that no staff approached the resident to prompt or assist the resident to toilet.
- Observations by Inspector #593 October 29, 2014 found that between 14:45 and 15:30, there was no attempt made to prompt the resident to toilet. During this time, the resident was seated in the bedroom reading.
- Observations by Inspector #593 October 30, 2014 found that between 08:45 and 09:20, there was no attempt made to prompt the resident to toilet. During this time, the resident was seated in their room.

As such, the licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. Inspector 151 inspected the MDS triggered issue of acute illness for resident #040. Inspector reviewed the resident's health care records and could find no evidence of resident having had a bout of acute illness; the only reference being 11 months prior. Inspector reviewed the resident's most recent MDS assessment dated Sept.10, 2014 and noted that the resident was coded as having acute illness. Inspector noted that for every MDS assessment since 11 months ago, the resident had the acute illness

coded as an active diagnosis. Inspector interviewed staff #206 and staff #203, both of whom confirmed that the acute illness was resolved 11 months ago. Inspector interviewed Staff #206 who confirmed awareness that only active diagnoses are to be coded and that this was an error in coding.

The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for residents #003,006,007,0020, and 0040, the resident's plan of care provides clear directions to staff and others who provide direct care to the resident and that the care provided to the resident is as specified for in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Throughout the two week Resident Quality Inspection process at the home and on a daily basis, Inspectors 151, 579 and 593 encountered staff not wearing name tags. The licensee has failed to ensure that residents are told who is responsible for and who is providing the resident's direct care [s. 3. (1) 7.]

2. Inspector 151 walked through the home daily and noted that in each resident's room and over the bed was posted a pink card summary of the resident's care plan that included personal health information of the residents toileting needs, side rail use, risk of falls, use of alarms, re-positioning needs, use of or lack of dentures and special instructions. These summaries are found for every resident in the home and the information is visible to all staff, families and visitors.

In an interview with Inspector 151, Director of Care confirmed that the resident's plan of care consisted of the following: hard copies of entire care plans held centrally on Snowy Owl unit, a written quick reference kardex at each nursing station and the over-bed postings in each resident's room.

The licensee did not ensure that the resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential in accordance with the Act. [s. 3. (1) 11. iv.]

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. Inspector 151 observed a medication administration pass. Inspector observed that on the medication cart, staff # 204 had pre-poured 4 medications and that these were sitting on the cart with no resident identifier as to who the medications were for or what the medications were. In answer to a direct question asked, staff # 204 stated that these 4 medications were 3 doses of Nutren Supplement and one 1 dose of Peg-Lyte: each of which held approximately 60 cc of liquid.

In an interview with Inspector 151, staff # 203, confirmed that pre-pouring of medication was against the home's policies and the practice was not according to College of Nurses standards: "we should not be doing this"

Inspector reviewed the home's policy titled; Administration of Medication; Medication and Treatment and Administration; last revised November 2004. Inspector noted a statement on page 1: "Medication is only administered by the registered staff member who has prepared the medication for immediate administration to a specific resident"

The licensee has failed to ensure that the home's policy related to medication administration was complied with. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. Inspector #593 observed a loose support post next to the commode in resident #022's bathroom. Further observations by Inspector #593 found the support post to still be loose the following day.

Inspector 593 reviewed resident #022's plan of care and noted the resident required the use of assistive devices to aid with transfers in bed, in the bathroom and for ambulation.

In an interview with Inspector #593, resident #022 confirmed the need to use the support pole in the bathroom to assist with toileting and dressing. The resident stated that the pole was useful in that it allowed independence in dressing without the assistance of staff.

During an interview with Inspector #593, staff member #212 confirmed responsibility for adaptive equipment used to assist resident mobility and transfers. Staff member confirmed that support/transfer poles in resident washrooms were not on any preventative maintenance program and that, to date, staff #212 was unaware any were loose. Staff #212 stated that it was the expectation that staff would report any equipment they found in disrepair.

Inspector #593 reviewed the home's commode log check audit completed September 2013. Inspector found no documentation indicating the support post in resident #022's room was checked.

As such, the licensee has failed to ensure that residents' safety equipment is maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. During an interview with Inspector #593, Resident Council President informed that the administration of the home responded to comments, concerns and suggestions from the Resident's Council verbally. At no time has anything been received in writing. Resident Council President went on to say the Council would prefer if the responses were provided in writing as they would like to have written proof of issues and concerns being managed.

During an interview with Inspector #593 October 28, 2014, Staff #202 confirmed that, historically, the response to Resident Council issues and concerns has only been in verbal format. The current process for response is to go to the inquiring resident's room and respond verbally to issues and concerns.

During an interview with Inspector #593 October 28, 2014, Staff #213 confirmed that responses from the homes management to issues and concerns are not given in writing.

During an interview with Inspector #593 October 27, 2014, Staff 201 confirmed that the home does not respond in writing to the Residents' Council regarding issues and concerns. Staff #201 stated that they would respond in writing if the issue was a complaint.

Inspector #593 reviewed Residents' Council minutes dated October, September and June 2014 and found that issues and concerns were raised at all three of these meetings. No written response to these issues and concerns was found.

As such, the licensee has failed to respond in writing after receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During an interview with Inspector #593 October 27, 2014, Resident Council President stated that the Residents' Council had not been consulted by the home regarding meal times and snack times in the home. In an interview with Inspector #593, Staff # 208 confirmed this fact.

As such, the licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council. [s. 73. (1) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. During an interview, Staff #202 apprised Inspector #593 that Resident Satisfaction Surveys are only carried out in the home every 3 years. The most recent was done in February 2014 and the one previous to this one was completed in 2011

As such, the licensee has failed to ensure that, at least once in every year, a survey is taken of the Residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. [s. 85. (1)]

2. During an interview with Inspector #593, Residents' Council President related that the Council has never been involved in the development of the home's satisfaction survey. In addition, the President has no recollection that the results of the survey were brought to and shared with the Council.

In an interview with Inspector 593, Staff #202 confirmed that the Council has not been involved in the development of the satisfaction surveys, the surveys have never been provided to the Council for review prior to distribution and that administration staff of the home have not formally hared the results of the surveys directly with the Council or consult them on the results.

As such, the licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

3. During an interview with Inspector #593, Resident's Council President related that the council has never been involved in the development of the home's satisfaction survey. In addition, the President has no recollection that the results of the survey were brought to and shared with the Council.

In an interview with Inspector 593, Staff #202 confirmed that the Council has not been involved in the development of the satisfaction surveys, the surveys have never been provided to the Council for review prior to distribution and that administration staff of the home have not formally shared the results of the surveys directly with the Council or consult them on the results.

As such, the licensee has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. Inspector #579 interviewed Staff 201, who confirmed the home's infection control program and policies were reflective and inclusive of that of the best practices recommended by PIDAC (Provincial Infectious Diseases Advisory Committee) for environmental surveillance and prevention of infections.

Inspector #579 reviewed the PIDAC document, specifically the information concerning "Best Practice Environmental Cleaning" (page 52). In section D. of this reference, it states “Clean linen should be transported and stored in a manner that prevents inadvertent handling or contamination by dust and other airborne articles'. In the section titled "Recommendations: 31, the reference states: " There must be policies and procedures to ensure that clean laundry is packaged, transported and stored in a manner that will ensure that cleanliness is maintained."

Inspector #579 interviewed staff #206 who reported and demonstrated to this inspector that the personal clothing carts go out to be delivered to home areas on mobile wire racks, and that the cart was not covered in transport.

Inspector #579 interviewed Staff #201 who reported that the linen delivery racks have never been covered while in transport or in storage.

Inspector #579 observed staff #209 who was dispensing towels and face cloths to resident rooms from a mobile cart in the hallway. The cart had no cover at that time. Inspector interviewed staff #209 who confirmed that historically, this cart has never been covered.

As such,the licensee has failed to ensure that there are measures in place to prevent the transmission of infections. [s. 86. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. In an interview with Inspector #579, DOC confirmed that she was the contact for Infection Control Management in the home and confirmed that the home has never invited the Medical Officer of Health to the infection control meetings.

The licensee has failed to ensure that the local Medical Officer of Health is invited to the Infection Prevention and Control team meetings. [s. 229. (2) (c)]

2. Inspector 151 observed the noon day meal service on October 21, 2014. Inspector observed the following infection control issues:
- Dietary Aide was observed to don gloves for the plating of food. This same Dietary Aide was observed to do the following without change of gloves; plating of food, coming out of servery and pushing a cart, putting hands on hips, coming out of servery and unlocking metal servery garage door and opening same and returning to servery and continuing to plate resident food
- A resident required tray service. The tray of food that included fluids, soup, entree and dessert was transported to the resident's room without any item being covered.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program [s. 229. (4)]

Issued on this 6th day of November, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIQUE BERGER (151), GILLIAN CHAMBERLIN (593), JANET MCNABB (579)
Inspection No. / No de l'inspection :	2014_395151_0007
Log No. / Registre no:	S-000433-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 6, 2014
Licensee / Titulaire de permis :	NORTH CENTENNIAL MANOR INC. 2 Kimberly Drive, KAPUSKASING, ON, P5N-1L5
LTC Home / Foyer de SLD :	NORTH CENTENNIAL MANOR 2 KIMBERLY DRIVE, KAPUSKASING, ON, P5N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDRE FILION

To NORTH CENTENNIAL MANOR INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan ensuring that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents . This plan is to include details on how the licensee will recruit and hire the services of a dietitian. In addition, the plan is to include the measures to be taken immediately and in the interim in order to meet the clinical and nutritional care of residents required of a dietitian and to meet all the requirements of the following regulations:
- nutrition and hydration programs; O.Reg.79/10, s. 68, (1) (a),(b) and 2. (a).(b).(c),(d),(e)
- weight changes; O.Reg.79/10, s. 69. (1)
- dietary services: O.Reg.79/10, s.70 (a)
- menu planning: O.Reg.79/10, s 71(1).(b.(c).(e).(f).(g) and (2).(a).(b), (4)

The plan is to be submitted to Inspector 151, Monique Berger by November 20, 2014 , at e-mail address: monique.berger@ontario.ca. Full plan implementation is required by January 03, 2015

Grounds / Motifs :

1. Inspector 151 observed the noon day meal and noted that only one of the posted menu entree choices was available to residents requiring texture modified puree diets. Dietary Aide and Staff #208 confirmed that the residents were only provided with one of the posted entree choices and that it was dietary staff who chose which entree would be prepared that day. Staff #208 confirmed

that most of the residents who require puree diets would be able to choose if presented with visual choices of the entrees.
The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.
As such, the licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to met the daily nutrition needs of the residents.

2. Inspector #579 and #151 reviewed the home's weight monitoring program policy: reference: MEASURING HEIGHTS AND WEIGHTS; POLICY NUMBER RCM-11-D - last revised November 2004. The policy states that Health Care Aides are to weigh the residents every month and " compare current readings with last month's weights and re-weigh if there is a change of 2 lbs or more" from the previous month's weight. Inspector 151 reviewed the policy with staff #203 who confirmed that the home was still following this policy.

In an interview with Inspector 151, Staff #201 stated that, in absence of a dietitian, Nursing and Staff #208 had assumed the responsibilities of nutritional care, however, there was no written protocol in regards to this. Registered Nurses and Staff #208 were responsible for monitoring residents' weights and were responsible for following up on weight loss/gain exception warnings generated by the home's software program in relation to each resident's percentage of weight change triggers at 1 month, 3 months and 6 months. On October 23, 2014, during the Resident Quality Inspection, Staff #201 submitted to Inspector 151 a draft referenced: NUTRITION AND HYDRATION; PROCEDURE TO FOLLOW IN ABSENCE OF DIETITIAN. Staff #201 confirmed that this document represented what the licensee had been doing since the loss of the dietitian in regards to the nutrition and hydration care of residents.

Inspector reviewed the weight history for 2 residents where it was noted there were 3 incidents where the resident's weight differed significantly from the previous month's weights. There was no indication for any of the 3 incidents, that the resident was re-weighed as per the home's policy as the next weight entry for each of the 3 incidents is for the following month.

Inspector 579 reviewed the document; WEIGHTS AND VITALS SUMMARY for all residents and for the dates range of July 30, 2014 to October 30, 2014 and noted multiple residents who had not had re-weighs entered for significant changes in weight within 1 month or 3 months and for whom the home's

software had entered exception alerts in regards to the significant weight deviations.

The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated:
a. A change of 5 per cent of body weight, or more, over one month
b. A change of 7.5 per cent of body weight, or more, over three months
c. A change of 10 per cent of body weight, or more, over 6 months
d. Any other weight change that compromises their health status
O.Reg.79/10, s. r. 69. 1.,r. 69. 2.,r. 69. 3.,r. 69. 4

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

3. Inspector #579 reviewed the Home's Policy and Procedure in the Subsection of Nutrition titled "Measuring Height & Weight: RCM-11 D effective November 2004 and noted that the document stated the Dietary Department " will calculate the resident's ideal body weight (IBW) from the admission height and weight and this will be recorded on the care plan".

Inspector 151 reviewed the home's policies and procedure titled: "Nutrition and Hydration Program"; November 1, 2012. Inspector noted a reference on page 8 of the policy program that states: “Evaluate resident's height and weight on admission, check height yearly and weight monthly".

Inspector #579 noted that in reviewing resident health care records for weights and heights of residents, it became apparent that the residents' heights were documented sporadically over varying years. Inspector #579, interviewed Staff #206 who stated that it was not the home's usual practice to measure residents’ heights on an annual basis. Inspector 151 reviewed the resident health care records for 13 residents and noted that only 3 of the 13 residents had a height recorded in the year 2014. Inspector #579 reviewed the Home's Policy and Procedure in the Subsection of Nutrition titled "Measuring Height & Weight: RCM-11 D effective November 2004 and noted that the document stated the Dietary Department " will calculate the resident's ideal body weight (IBW) from the admission height and weight and this will be recorded on the care plan".

The licensee has failed to ensure that there is a weight and height monitoring system to measure and record each resident's body mass and height on admission and annually thereafter

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.
(151)

2. In an interview with Inspector 151, Staff #201 and Staff #202 confirmed that the home has been without a dietitian for the last 2 years. Staff #201 confirmed that the home did have residents with skin and wound issues, though wound rate was below provincial average. Staff #201 confirmed there has been no ability to refer residents with wound and skin integrity issues for dietary assessment, as there is no dietitian.
Due to the lack of the services of a dietitian, those residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have not:
* been assessed by a registered dietitian who is a member of the staff of the home, and
* had any changes made to the plan of care related to nutrition and hydration been implemented

As such, the licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.
(151)

3. In an interview with the Inspectors, Staff #201 and Staff #202 confirmed the home has been without a dietitian for the last 2 years. Through Inspector 151's review of residents' health care records and Inspector 579's review of the last 3 months of resident weight histories, Inspectors noted the home is not following their re-weigh policies when weights taken have a 2.5 pound difference. Inspector's noted examples where software generated triggered weight warnings went as long as 3 months before being addressed and/or corrected. Inspectors 151 and 579 noted that in reviewing resident health care records, residents were not being measured for height on an annual basis as per the home's policy: this having influence on the accuracy of BMI (body mass index) and IBW (ideal body

weight) calculations

In an interview with Inspector 151, both the DOC and staff # 206 confirmed that the residents' weights and attention to software generated warnings of weight changes have not been consistently monitored and assessed. Both Staff #201 and Staff #206 confirmed that the home's draft plan "Procedure to Follow in Absence of Dietitian" has not always been followed.

Because there has been no registered dietitian at the home for the last 2 years, the requirements for the registered dietitian who is a member of the staff of the home to do the following has not been met:
(a) complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition; and
(b) assess the resident's
- nutritional status, including height, weight and any risks related to nutrition care, and
- hydration status, and any risks related to hydration

As such, licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.
(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 03, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 241. Trust accounts

Order / Ordre :

The licensee shall prepare, submit and implement a plan that will ensure all requirements of O.Reg.79/10, s.241 in regards to resident trust funds are complied with.

The plan is to be submitted by November 20, 2014 and forwarded to Inspector 151, Monique Berger at the following e-mail address: monique.berger@ontario.ca. The plan is to be fully implemented by December 31, 2014

Grounds / Motifs :

1. In an interview with the Inspector 151, Staff # 207 confirmed that the home held trust funds for 77 of their 78 residents. Manager confirmed that funds entrusted to the home on behalf of a resident [Trust Funds] were held in an interest bearing account with the local financial institution.

Inspector 151 reviewed the statement of account for the month of September 2014 from the financial institution where the deposits for the trust funds are held and noted that the account did have interest money paid to it. Manager of Finance stated that he did not know where in the home's finance system this interest was being credited to.

The licensee did not establish and maintain one non-interest bearing trust account at a financial institution for depositing money entrusted to the licensee's care on behalf of a resident
(151)

2. In an interview with the Inspector 151, Staff # 207 confirmed that the home does not have written policies and procedures for the management of trust accounts.

The licensee has failed to ensure that there are policies and procedures for the management of trust accounts and the petty cash trust money that include:
(a) a system to record written authorizations, and
(b) the hours when the resident or persons acting on behalf of the resident can make deposits or withdrawals from the funds in a trust account and from petty cash trust money
(151)

3. In an interview with the Inspector 151, Staff # 207 confirmed that the home does not have written policies and procedures for the management of trust accounts and as a result, no resident or their representative have written information on the home's current process in the management of trust accounts.
The licensee has failed to ensure that the policy and procedures for the management of trust accounts and petty cash trust money have been provided to every resident and person acting on behalf of a resident who asks to have money deposited into a trust account
(151)

4. In an interview with Inspector 151, Staff # 207 confirmed that unless a resident or their representative specifically requests it, no receipt is provided for money deposited into a trust account.

The licensee has failed to ensure that a receipt is provided to the resident for money deposited into a trust account.
(151)

5. In an interview with Inspector 151, Staff # 207 confirmed that unless a resident or their authorized representative specifically requests it, no quarterly statements are provided. Only 2 residents of the 77 who have funds held in trust by the home have requested and are receiving quarterly statements.

The licensee has failed to ensure that itemized statements provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident, that include:

* deposits
* withdrawals, and
* the balance of the resident's funds as of the date of the statement

(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MONIQUE BERGER

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