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

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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
Sep 4, 5, 2014	2014_198117_0022	O-000778-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

RESIDENCE CHAMPLAIN
428 Front Road West, L'Orignal, ON, K0B-1K0

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

LYNE DUCHESNE (117), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550)

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): August 18, 19, 20, 21, 22, 25, 26, 27 and 28, 2014

A Critical Incident Inspection, Log # O-000820-14, was also conducted concurrently during this Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), the Food and Nutrition Manager, Program Manager, Business Manager, Nursing Staffing Coordinator, MDS RAI Coordinator, Restorative Care Aide, Behavioural Support Ontario (BSO) worker, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), dietary aide, environmental worker, housekeeper, several residents, several family members, President of the Resident Council and a member of the Family Council.

During the course of the inspection, the inspector(s) reviewed residents health care records; observed resident care and services; observed the lunchtime meal of August 18, 2014; observed resident rooms, common areas and equipment; observed medication administration pass on August 22, 2014; reviewed home's registered nursing staffing schedule of June, July and August 2014; reviewed Resident Council Meeting Minutes from June 2013 to July 2014; reviewed Family Council Meeting Minutes from June 2013 to July 2014; reviewed the home's Resident Admission Information Package; reviewed the home's maintenance book; reviewed the home's Fall Prevention Program and Infection Control Program; reviewed the following policies: Falls Program - Incident Reporting, Analysis and Prevention Strategies # RRCS-E-20, dated January 2013; Safety-Falls-Resident # LTCE-CNS-G-10, dated Feb 2007; Resident Abuse #RCA-LTCE-02 RCAM-IV-15, revised July 2010; Medication Administration #LTCE-CNS-F-1, revised January 2013; Order/Reordering/Destruction of Drugs # LTCE-CNS-F-16, revised April 2014; Drug Record Book; Precautions Required-By Infections Disease # LTCE-INF-C-06, dated August 2012; Continence Care- Clinical Procedures # LTCE-CNS-B-05, dated May 2012; and reviewed a Critical Incident Report.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, C.8, s. 8. (3) in that the long-term care home did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

As part of the RQI Inspection, a review of the home's Registered Nurse Staffing Schedule was conducted. The registered nursing staffing schedule from June 22, 2014 to August 27, 2014 was reviewed.

As per the reviewed schedules, there was no registered nurse on duty and present in the home for the following 25 shifts:

June 22 and 30, there was no RN on the evening shift.
June 23 there was no RN on the day shift

July 3, 7, 12, 13, 17, 21 and 31 there was no RN on the day shift
July 1, 11, 15, 20 and 29 there was no RN on the evening shift
July 4 there was no RN on the night shift

August 4 and 18 there was no RN on the day shift
August 2, 15, 22, 23, 24, 26 and 27 there was no RN on the evening shift

On August 25, 2014, the home's DOC confirmed to Inspector #117 that on the above dates, there was no RN on site in the home. The DOC stated that since mid-June 2014, the home has been having difficulties in ensuring that there is a registered nurse (RN), on site, 24 hours per day, due to staff holidays and unexpected leaves of absences. The home currently has two part-time RN positions that are vacant. The home has been actively recruiting for these positions with little success to date. The DOC stated that the home does have a contract with a staffing agency that provides RN services to the home. However, even with agency RN staffing, the home has been without an RN on site on several occasions during the past few weeks.

The DOC stated to Inspector #117, that when there was no RN on site, two regular staff RPNS were working in the home and that he was either present in the home or was on-call and available by phone to address any nursing issues.

It is noted that the long-term care home has 60 beds. Under O.Reg. 79/10, s. 45 (1), homes with a licensed bed capacity of 64 beds or fewer,

i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or

B. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

Under O.Reg. 79/10, s. 45. (2) an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

As per the above reviewed information, there was no unforeseen situation of a serious nature that prevented a registered nurse from getting to the long-term care home. Therefore the licensee did not ensure that there was a registered nurse on site at all times, in the long-term care home.

It is noted that a finding of non-compliance was issued on October 22, 2012, during Inspection # 2012-198117-0002. A Voluntary Plan of Correction (VPC) was issued under LTCHA 2007, s. 8 (3) as it relates that there was no registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, on duty and present in at the home at all times. [s. 8. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (a) in that the licensee did not ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

On a specified day in July 2014, Resident #10's attending physician ordered an indwelling catheter to help with the healing of wounds. A catheter was inserted on that day and care of indwelling catheter was provided.

On August 25, 2014 Inspector #545 observed Resident #10 with his/her right pant leg up exposing a leg bag with a small amount of clear urine. Resident #10 indicated that the elastics holding the leg bag was hurting him/her as it was too tight.

In a review of Resident #10's current plan of care, no written information regarding catheter care was found in the plan of care. During interviews with PSW S#104 and RN #S102,the staff indicated to Inspector #545 that the plan of care had not been updated on the specified day in July 2014 when an indwelling catheter was ordered and inserted.

During an interview with the DOC on August 25, 2014, the DOC indicated to Inspector #545 that the plan of care should have been updated to include catheter care, as per the home's expectation. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, S.O.2007, C.8, s. 6 (1) (a) in that

the long-term care home did not ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #4 has an advanced neurodegenerative disease and several pressure ulcers. Resident #4 was observed during the Resident Quality Inspection (RQI) by Inspector #117 to be in lying in bed all the time. Resident #4 stated to the Inspector that he/she stays in bed all the time due to the advanced neurodegenerative disease, wounds and due to the pain that the resident has when he/she is up in a wheelchair. The resident was unable to tell the Inspector since when he/she has been bed fast.

On August 27, 2014, registered staff RPN S#114 and S#101 stated to Inspector #117 that Resident #4 has been bed fast for the past 1-2 years due to his/her medical condition, wounds and generalized pain. They stated that the resident rarely gets up in his/her wheelchair. When the resident is up, he/she stays in the wheelchair for approximately 1 hour and then needs to be returned to bed due to pain and discomfort. PSW staff members S#103 and S#111 confirmed that the resident is bed fast, that Resident #4 gets his/her meals in his/her room and is fed while in bed with staff assistance and that all of care and activities occur while the resident is in bed.

A review of the resident's current plan of care was conducted. The plan of care does not identify that the resident is bed fast, that he/she receives all of his/her care and meals in bed and that activities are done at bedside. The plan indicates that Resident #4 is a 2-person mechanical lift transfer to a wheelchair. Upon indepth review of the resident's chart, information was found indicating that the resident has been bed fast since August 2012 due to the resident's decline in health status.

Resident #4's written plan of care does not set out the planned care for the resident as it does not identify that the resident is bed fast, that all care, activities and meal service/assistance is done at the resident's bed side and that the resident has limited use of his/her wheelchair. [s. 6. (1) (a)]

3. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #7's plan of care, dated July 2014 indicates that the resident is alert and oriented with a mild cognitive impairment and that the resident is at high risk for falls.

The plan indicates that staff are to ensure appropriate safety device such as clothing alarm is in place and to remind resident to call for assistance and wait before getting up. It was also documented that resident requires extensive assistance of one person for transfers, using a transfer belt.

On August 26, 2014, Inspector #545 observed Resident #7 sitting in his/her wheelchair in the TV room and no clothing alarm in place. During an interview with Resident #7, he/she indicated that even though he/she was afraid of falling and breaking a hip, as the resident had done in the past, the resident still went to the bathroom on his/her own during the day.

During an interview with PSW S#109, the staff member indicated to Inspector #545 that a clothing alarm is not used for Resident #7. PSW S#109 indicated that she had access to the plan of care but was not aware that the most recent plan of care indicated that a clothing alarm was required to ensure Resident #7's safety. When asked, the RAI-Coordinator back-up indicated that the clothing alarm had been discontinued at the end of June 2014 but she could not understand why it was as Resident#7 remained at risk for falls as he/she consistently transfers self to the toilet without requesting assistance from staff. The RAI-Coordinator indicated that she would be reviewing the clothing alarm and recommend that it be re-instated as per the plan of care.

As such, the care set out in the plan of care such as ensuring that the clothing alarm safety device was used, was not provided to Resident #7 as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #10's written plan of care set out the resident's catheter care needs; that Resident #4's written plan of care set out the resident's status as being bed fast, the bedside care and services that she receives and her limited use of a wheelchair; and that Resident #7 fall prevention interventions are provided to the resident, as identified in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 49 (2) in that the home did not ensure that when the resident has fallen, the resident was assessed and, if required, a post-fall assessment be conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #6's plan of care, dated July 2014, indicates that Resident #6 has severe cognitive impairments and is at high risk for falls. The most recent RAI-MDS 2.0 assessment, dated July 2014 indicated that Resident #6 was unsteady, had conditions or disease that made resident's cognitive, ADL (activities of daily living), mood or behaviour unstable. The assessment also indicated that Resident #6 had falls in the past 30 days as well as the past 180 days.

On August 19 and 22, 2014, Resident #6 was observed in his/her bedroom sitting in a reclined wheelchair with a front closure seat belt and a padded table tray. The wheelchair was placed between 2 beds, Resident #6 was alone, resting and calm. A bed alarm was also observed on his/her bed.

During an interview with RN #S102, the RN indicated to Inspector #545 that Resident #6 had fallen 4 times since April 2013 and that a post-fall assessment was only completed one time, this on a specified day in April 2013. The RN indicated that according to the home's Falls policy and the Post Fall Analysis Process Map, a resident that is identified at high risk for falls requires a post-fall assessment when they have fallen the first time in a quarter. She confirmed that a post-fall assessment was not completed on the following dates when Resident #6 had fallen:

- On a specified day in July 2014 - Resident #6 was found hanging on the foot of the bed, resident had removed lapbelt and padded table top, a small bruise was noted on the knee.

- On an specified day in July 2014 - Resident #6 removed padded table top, detached lapbelt and slid from wheelchair, no obvious injuries.
- On a specified day in April 2014 - Resident #6 was found sitting on the floor in front of his/her wheelchair, the padded table top was removed and the lapbelt was undone, no apparent injuries were noted.
- On a specified day in December 2013 - Resident #6 was found sitting on the floor beside his/her bed, seat belt unbuckled, table under his/her bed, Resident was complaining of pain to a hip. Family was notified. Resident was sent to hospital for further assessment, returned several hours later with no apparent injuries.

During an interview with the Director of Care on August 22, 2014, the DOC indicated that a post-fall assessment should have been completed when Resident #6 fell on twice within 1 week in July; once in April 2014 and once in December 2013.

The home did not ensure that a post fall assessment was conducted when Resident #6 sustained 4 falls, some with and without injuries, twice within 1 week in July 2014, once in April 2014 and once in December 2013. [s. 49. (2)]

2. Resident #7's plan of care, dated July 2014 indicates that the resident is alert and oriented with a mild cognitive impairment and that the resident is at high risk for falls.

Chart documentations indicates that in the early evening of a specified day in February 2014, Resident #7 was found on the floor between his/her bed and the closet, attempting to change his/her brief. A small open injury was observed the following day.

During an interview with RN #S102, the RN indicated to Inspector #545 that a post-fall assessment was not done for Resident #7 for the fall that occurred on a specified day in February 2014 because this fall was the resident's the second fall in that quarter. Resident #7 had fallen on a specified day in January 2014 when transferring himself/herself to the wheelchair and a post-fall assessment was completed at that time. RN #S102 indicated that the home's process was followed.

The home did not ensure that a post fall assessment was conducted when Resident #7 who sustained two falls within one month, one with injuries, on specified day in January and the other on a specified day in February 2014. [s. 49. (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 when Residents #6 and #7 fall, a post fall assessment be completed, using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 85. (3) in that the licensee did not seek the advice of the Resident Council and the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

On August 25, 2014, the home's Activity Manager S#112, President of the Resident's Council and a Family Council member stated to Inspector #117, that the home did not seek the Resident Council's and Family Council's advice in the development and carrying out of the 2014 annual satisfaction survey.

The Activity Manager S#112 and the Family Council member stated that both Resident and Family Councils had been consulted in the development of the 2013 annual survey but not the 2014 annual survey.

On August 27, 2014, the home's Administrator confirmed that neither Resident or Family Councils had been consulted this year in the development and carrying out of the home's annual satisfaction survey that was completed in August 2014. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home seek that advice of the Resident and Family Councils in the development and carrying out of the home's annual survey, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventive and remedial maintenance.

Observations done by Inspectors #117, #545 and #550 during the stage 1 of the RQI. The Inspectors observed the following:

- West wing tub and shower room: The shelves next to the tub and the shower are made of melamine; the melamine is worn exposing particle board on all shelves. The electrical outlet next to the tub has a radio plugged in one outlet and the other outlet has a three way splitter plugged in. The splitter has one cord for the emergency light, a cord for a lift charger and a cord for an angel holding a light. There is a strong urine smell in the room. The back of the room door had many indentations some exposing the wood. The top left corner of the door and the bottom of the door is coming undone, exposing the wood. The left bottom corner of the metal frame is rusted. The seams in the linoleum on the floor in both corners of the shower are broken letting water in. The plastic plates covering the seams joining the bottom of the wall and the linoleum baseboard in the shower is not sealed. They are soiled with a brown liquid that smells

like urine. The wall over the sink in the toilet is covered with some material imitating ceramic tiles; it has visible water damage which is exposing porous material. The seam in the linoleum baseboard next to the toilet door is undone and cannot be cleaned properly.

- In room 129, the bathroom door frame has lower section of metal frame with scrapped paint exposing the metal underneath.

- In rooms 129, 111, 117, 116, 110, 112 on the wall between the electric baseboard and the window the paint is cracked and peeling exposing the gyprock and wall screws.

- In room 134: In the resident's washroom the tub is stained with lime deposit and rust, cannot be properly cleaned, the linoleum baseboard is coming unglued, the seam in the left corner under the sink is broken, the baseboard heater is rusted and the metal door frame to the washroom the bottom is rusted.

- In room 132: The wall in behind the bed was repaired with plaster and it was not painted over. The wall surface cannot be cleaned properly. The wall on the right side of the window is cracked, the wall under the window is cracked, the paint is chipped and there is a small hole in the gyprock.

- In room 116: Folding closet doors 116-D the vinyl kick plate was removed, exposing dried brown glue and paint chipped off. The baseboard heater is rusted and paint chipped off. There is a hole in the window frame at the bottom of the left hand side window where cables are coming in; the wood frame is broken exposing the wood.

- Room 110: vinyl kick plate on closet doors is missing, on one side of each folding doors and one on the folding door 110-C is coming off, very loose. Dried brown glue is exposed, and some paint is chipped off both doors. On the wall between the windows, some of the paint is removed exposing the gyprock, several screw holes are observed. The ceiling has visible water stain and cracked ceiling. Two holes the sizes of a dime are noted on the ceiling over bed A and are covered with tape. The wall in the washroom over the sink and on the right hand side is covered with some type of board imitation of ceramic. This board has visible water damage and is exposing porous material.

- Room 112: The wall above the sink and on the left side of the sink is covered with

some type of material imitating ceramic tiles. This material has visible water damage and is exposing porous material. The wall under the windows is cracked; paint is coming off exposing porous material. (Inspector #550)

The hand rails in East and West hallways, the paint is chipped and the varnish is used exposing the wood making it difficult to keep clean and sanitary.

Inspector #550 reviewed the maintenance book from October 26, 2013 to August 28, 2014, and none of the identified issues in this report were noted to have been reported in the home's maintenance book.

During an interview with staff #S117 and #S121, the staff members both indicated to Inspector #550 that whenever there is a repair needing to be done in a resident's room, they write the maintenance issue down in the maintenance book. When Inspector #550 reviewed with them some repairs needing to be done in some resident rooms and bathrooms, both staff members indicated that these have probably been reported and documented in the home's maintenance book and that the home's maintenance person just did not have time to get to it.

During an interview with the home's maintenance person S#126, the staff member indicated to Inspector #550 that the home's staff are to report any repairs to be done in the home in the maintenance book, that is kept at the West nursing station. S#126 states that every morning he verifies this book and performs the work needing to be done. He stated to the Inspector that he was aware of certain maintenance issues in the West Wing tub and shower room as well as in some of the resident rooms but that there was no plan in place to address the identified issues.

Inspector #550 discussed the home's maintenance processes and reviewed the home's maintenance book with the home's Administrator. The Administrator indicated that the home conducts random audits on a monthly basis of resident's rooms, tub and shower rooms. The Administrator confirmed that the maintenance issues brought to her attention by Inspector #550 were not identified in the maintenance book or the home's monthly audits. The Administrator stated to Inspector #550 that the home does not have schedules and procedures in place for routine, preventative and remedial maintenance of the resident's rooms, tub and shower rooms. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has schedules and procedures in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place is complied with.

In accordance with O.Reg. 79/10, s. 136 (2) (1), the drug destruction and disposal policy must provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The home's policy No. LTCE-CNS-F-16 titled "Oder/reordering/destruction of Drugs; Drug record book" revised April 1, 2014 indicates on page 4, number 2. "Medications for destruction are to be placed in the designated container for bio-hazardous waste with a lid or other such feature that prevents the removal of the medication and stored separately from drugs available for administration".

Inspector #550 did an observation of the medication storage room located next to the nursing station in the West wing. This room is used to store medications and dressing supplies. All government supply medication, resident's stock medication and dressing supplies are stored on open shelves in the storage room and the emergency stock medications are stored in a plastic unit with drawers mounted on the wall. There is a white plastic container labelled ''Stericycle'' on a cupboard. The Director of Care indicated to Inspector this container is used to collect all non-controlled medications that are to be destroyed. The Registered staff will put all medications that are to be destroyed in this container. When the container is full, the Director of Care denatures the medication and then stores the container in another storage room until it is picked up by Stericycle and removed from the home.

The home does not follow their policy as the medications to be destroyed are not stored separately from drugs available for administration. [s. 8. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On a specified day in August 2014, the Nursing Staff Coordinator overheard PSW #S120 and RPN #S119 using derogatory verbal abuse towards Resident #13. The Nursing Staff Coordinator immediately reported the incident to the DOC, who subsequently initiated an investigation into the incident.

During an interview with the Director of Care (DOC) on August 28, 2014, the DOC stated to Inspector #545 that he initiated the critical incident report the day after the incident, as part of the investigation process, but that it was only submitted to the Director three days later when he was informed by the home's consultant that the incident of verbal abuse had not been reported to the Director. The DOC indicated that he was aware that he needed to immediately report the suspicion and the information regarding abuse of Resident #13 by PSW #S120 and RPN #S119 that resulted in harm or risk of harm upon which it was based to the Director. The DOC stated that he did not notify the Director by telephone or by the after-hours emergency pager, of the incident as he thought that by initiating the electronic critical incident report, the Director would have been notified even though the report was not be submitted electronically to the Director until a specified day in August 2014, 4 days after the incident occurred. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 53 (4) in that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #2 has a neurodegenerative disease and cognitive impairments with verbal and physical aggression.

On August 18, 2014, Inspectors #545 and #550, observed during the lunch time meal service, Resident #2 to become suddenly verbally aggressive towards staff and other residents and was not easily redirected by staff.

On August 22, 2014, registered staff S# 102 and S#106 stated to Inspector #117, that Resident #2 has frequent unpredictable episodes of verbal and physical aggression towards staff. These include: accusing staff of abuse during mechanical lift transfers in/out of bed when resident is identified as having chronic pain due to pressure ulcers and the neurodegenerative disease; accusing staff of stealing when resident has misplaced personal items and accusing staff of refusing to provide certain foods when resident is on a minced texture diet due to eating and swallowing difficulties.

A review of Resident #2's health care record documents that the resident has frequent unpredictable episodes of verbal and physical aggression. Since June 2014, Resident #2 has been on the Behavioural Support Ontario (BSO) program. PSW staff #110 is the home's BSO champion. She stated to Inspector #117 on August 26, 2014, that the

home is in the process of identifying behavioural triggers for Resident #2's sudden and unpredictable behaviours. Staff member S#110 indicated that some behavioural triggers such as pain and transfers have been identified but are not in the resident's plan of care. Staff member #110. She stated that some interventions are being trialed such as limited transfers in/out of bed, scheduled 1 on 1, age specific activities and use of a white board to communicate daily menus.

These interventions were observed to be in implemented by regular staff by Inspector #117 during the RQI inspection. PSW S#110 stated that the implemented interventions to help manage Resident #2's behaviours are not identified in the resident's plan of care. These interventions were communicated verbally to nursing staff for trial implementation. This information was confirmed on August 26, 2014, by PSWs S# 107 and S#108.

Resident #2's health care record was reviewed and there was no documentation identifying any the resident's sudden and unpredictable responsive behaviours, associated behavioural triggers such as pain and transfers, identified trialed interventions implemented by the BSO champion and the resident's response to these interventions. [s. 53. (4) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing.

The Long Term Care Homes Act, 2007 O.Reg. 79/10, s. 136 (6) defines a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

A review of the home's medication destruction processes was done as part of the RQI. During an interview with the Director of Care, he indicated to Inspector #550 that when non controlled substances are no longer in use, the medication are placed in a white pail, in the medication storage room, by a registered staff. When this pail is full, the DOC pours water in the pail to destroy the medication and then brings the pail to the locked storage room until it is picked up at a later date by Stericycle for disposal. The DOC states that he does this on his own. When Stericycle picks up the pails, the number of pails/unit that are sent to Stericycle are recorded and signed by the DOC and a registered staff on the "Non-narcotic and non-controlled drugs medication destruction records".

Non-controlled drugs and substances within the home are not being destroyed in a team composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing. [s. 136. (3) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 s. 224 (1)in that the long-term care home did not ensure that the package of information provided for in section 78 of the Act includes information about the following: 1. The resident’s ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1).

During the RQI inspection, a review of the home’s Resident Information Package was conducted. It was noted that there is no information in the package related to the resident’s ability to retain a physician or a registered nurse in the extended class to perform the services required under subsection 82 (1) of the Regulations.

On August 25, 2015, the home’s Business Manager reviewed the Resident Information Package with Inspector #117. She confirmed that the package does not contain any information related to the retention of physicians or registered nurses in the extended class. The unit RN S# 102 and the home’s Administrator confirmed that new residents are not given any written information related to the retaining of a physicians or a registered nurse in the extended class. They stated that residents are given verbal information about the home’s two attending physicians and are asked which physician the new resident would like to retain for their medical services. [s. 224. (1) 1.]

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. (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. The licensee has failed to comply with O.Reg 79/10 s. 229 (4) in that the home did not ensure that staff participate in the implementation of the infection prevention and control program.

On August 25, 2014 between 13:30 and 13:45 Inspector #545 observed PSW #S109 entering Resident #10's room to empty the catheter bag. The PSW had blue gloves on when entered the room holding an empty white plastic disposable container, known as

a "nun's cap". After checking Resident #10's catheter bag, PSW left the room with the same gloves on and the "nuns cap" indicating that it didn't require emptying. Inspector #545 did not observe PSW #S109 removing gloves, changing gloves or washing her hands.

On August 26, 2014 during an interview with PSW #S109, the staff member indicated that it was her practice to empty all four resident catheter bags' using one "nun's cap", added that once completed the task of emptying all catheter bags, she puts the one used "nun's cap" in a plastic garbage bag then throws it in the garbage bag available in the hallway. PSW #S109 indicated she was aware contact precautions were required when providing care to Resident #10. She indicated that it was her practice to wash her hands after emptying each catheter and to done a clean pair of gloves.

Four residents in the home have an indwelling catheter requiring emptying of bag once per shift and as required: Resident #4, #10, #17 and #18. Resident #10 is diagnosed with an infection.

Upon review of the Personal Support Worker Guidebook, it was noted on page 16 of 71, item 7 under the Catheter Care Drainage/Leg Bag that PSW were responsible to "rinse measure with antiseptic solution, then water after single resident use".

During an interview with the Director of Care on August 26, 2014, he indicated that staff are directed to use one clean measuring cup for each Resident who has a catheter bag requiring emptying. He indicated that the soiled measuring cups are to be brought to the Soiled Utility Room for the night staff to clean them.

PSW staff did not implement the home's infection control practices when they failed to follow item 7 under the Catheter Care Drainage/Leg Bag procedures to "rinse measure with antiseptic solution, then water after single resident use" for four residents who have foley catheters, one of which has an infection. [s. 229. (4)]

2. During the initial tour of the home on August 18, 2014 Inspector #545 observed a Contact Precaution sign posted on the following bedroom doors: 14, 106, 109, 111, 112, 116, 126, 132 138; no Personal Protective Equipment (PPE) carts were observed near any of the identified rooms. When asked, Housekeeping Aide #S116 indicated that the PPE caddys are located behind the Residents' bedroom doors; added that a Contact Precaution sign was also posted at the head of the Resident requiring

contact precautions. She indicated that at the moment, no resident in the home required contact precaution as she would have been informed at the beginning of her shift.

Upon review of the home's Precautions Required - By Infections Disease, Policy No. LTCE-INF-C-06, it is noted on page 1 of 10 that "to ensure that the correct level of precautions are in place for the direct care of any resident who is potentially infections, staff will be advised through signage of the appropriate required PPE" and that "signage will be posted on the resident's room door and/or at the bedside.

On August 26, 2014 during an observation, Inspector #545 noted that room 14 had no Contact Precaution sign at the bedside of residents in beds A or B and no Personal Protective Equipment (PPE) caddy behind the bedroom door. Room 109 had a PPE caddy behind the bedroom door but no Contact Precaution sign at the bedside of residents in beds A, B, C or D.

During an interview with the DOC on August 26, 2014 he indicated that the Contact Precaution sign in room 14 should have been removed 2 weeks ago when both residents suffered diarrhea which was resolved within 24-hours. The DOC indicated that Resident #4 tested positive for an infection on a specified day in June 2014 and a Contact Precaution sign at the bedside of Resident #4 in room 109 should have been posted that room had 4 residents. The DOC immediately directed staff to post a Contact Precaution sign at the bedside of Resident #4. [s. 229. (4)]

Issued on this 11th day of September, 2014

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

Ministry of Health and Long-Term Care

Ministére 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

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) :	LYNE DUCHESNE (117), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2014_198117_0022
Log No. / Registre no:	O-000778-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 4, 5, 2014
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	RESIDENCE CHAMPLAIN 428 Front Road West, L'Orignal, ON, K0B-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUCIE GOLDEN

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home has at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations. The plan shall also include all recruiting and retention strategies.

This plan must be submitted in writing to Lyne Duchesne, LTCH Inspector at 347 Preston St, 4th floor, Ottawa ON, K1S 3J4 or by fax (613) 569-9670 on or before September 12, 2014.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, C.8, s. 8. (3) in that the long-term care home did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

As part of the RQI Inspection, a review of the home's Registered Nurse Staffing Schedule was conducted. The registered nursing staffing schedule from June 22, 2014 to August 27, 2014 was reviewed.

As per the reviewed schedules, there was no registered nurse on duty and present in the home for the following 25 shifts:

June 22 and 30, there was no RN on the evening shift.
June 23 there was no RN on the day shift

July 3, 7, 12, 13, 17, 21 and 31 there was no RN on the day shift
July 1, 11, 15, 20 and 29 there was no RN on the evening shift
July 4 there was no RN on the night shift

August 4 and 18 there was no RN on the day shift
August 2, 15, 22, 23, 24, 26 and 27 there was no RN on the evening shift

On August 25, 2014, the home's DOC confirmed to Inspector #117 that on the above dates, there was no RN on site in the home. The DOC stated that since mid-June 2014, the home has been having difficulties in ensuring that there is a registered nurse (RN), on site, 24 hours per day, due to staff holidays and unexpected leaves of absences. The home currently has two part-time RN positions that are vacant. The home has been actively recruiting for these positions with little success to date. The DOC stated that the home does have a contract with a staffing agency that provides RN services to the home. However, even with agency RN staffing, the home has been without an RN on site on several occasions during the past few weeks.

The DOC stated to Inspector #117, that when there was no RN on site, two regular staff RPNS were working in the home and that he was either present in the home or was on-call and available by phone to address any nursing issues.

It is noted that the long-term care home has 60 beds. Under O.Reg. 79/10, s. 45 (1), homes with a licensed bed capacity of 64 beds or fewer,

i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing

staff is available by telephone, or

B. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

Under O.Reg. 79/10, s. 45. (2) an “emergency” means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

As per the above reviewed information, there was no unforeseen situation of a serious nature that prevented a registered nurse from getting to the long-term care home. Therefore the licensee did not ensure that there was a registered nurse on site at all times, in the long-term care home.

It is noted that a finding of non-compliance was issued on October 22, 2012, during Inspection # 2012-198117-0002. A Voluntary Plan of Correction (VPC) was issued under LTCHA 2007, s. 8 (3) as it relates that there was no registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, on duty and present in at the home at all times. (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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 4th day of September, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

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