Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 22, 2016	2016_205129_0011	022369-16, 023352-16, 023360-16, 023756-16, 023787-16, 024059-16, 024288-16, 024848-16, 027845-16, 028674-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD STONEY CREEK ON L8E 5J2

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

PHYLLIS HILTZ-BONTJE (129), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 12, 16, 17, 18, 19, 22, 23, October 6, 7, 13, 14, 17, 18, 19, 20 & 21, 2016

The following complaints and critical incidents were inspected during this inspection: Complaint #023756-16 related to abuse, Administrator hours, medication administration, lift and transfers; #024288-16 related to abuse; #024059-16 related to abuse, nursing department staffing, responsive behaviours and resident deaths; #027845-16 related to assessment/hospitalization, nursing leadership hours of work and #028674-16 related to retaliation/neglect, deaths, meal service and assisting residents, injuries to an identified resident and change in medication. Critical Incident #023352-16 related to abuse; #022369-16 related to lift/transfer; #023360-16 related to bruising/injury; #3023787-16 related to injury, and #024848-16 related to lift/transfer were also reviewed during inspection.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Acting Administrator, Administrator, Acting Director of Care (A-DOC), Director of Care (DOC), Personal Support Workers (PSW), recreation staff, Registered Practical Nurses (RPN), Registered nurses (RN), the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Physician, Environmental Manager and Foot Care Nurse. During this inspection residents were observed, clinical records were reviewed, staffing plans and schedules were reviewed, training records were reviewed, annual program evaluations were reviewed as well as policies and procedures were reviewed (Zero Tolerance of Abuse and Neglect, Management of Responsive Behaviours, Lift and Transfer and Foot Care).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was protected from abuse.
In accordance with the definition of physical abuse identified in the Long Term Care Homes Act, 2007, Ontario Regulation 79/10 resident #002 was physically abused by Personal Support Worker (PSW) staff # 603 and PSW staff # 607 when physical force was used in order to provide care to resident #002 and the following day the resident reported that they had sustained an injury.
A review of information provided by the home indicated on an identified date, PSW staff # 607 and PSW staff # 603 approached resident #002 to provide care. PSW staff #607 described the resident at that time as demonstrating responsive behaviors. PSW staff #607 indicated that this was the second time they had approached the resident in order to provide care.
During an interview PSW staff #603 confirmed that when they were providing care on the identified date, the resident was in bed and the bed rails were raised. This staff person went on to explain that they restrained the resident in order to provide care. PSW staff # 603 confirmed that they continued to provide care to the resident while the resident continued to demonstrate responsive behaviours. This staff person confirmed that they had not reported the resident's responsive behaviours to the charge nurse.
During an interview PSW staff # 607 confirmed that while they were attempting to provide care to the resident on the identified date, the resident continued to demonstrate responsive behaviours and they continued to provide care.
During an interview staff # 604 confirmed that the following evening, resident #002 approached them, they noted that the resident appeared to be in pain and the resident reported an incident and an injury they believed had been sustained during the incident. Staff # 604 was at the nursing station and immediately reported this to registered staff #606.
During an interview registered staff #606 confirmed that they were told by staff #604 that the resident had reported an injury. Registered staff #606 assessed the resident, the resident was able to move the affected body part without difficulty and the resident did not appear to be in pain. When asked if they continued to monitor the resident related to this reported injury they indicated they had, but they had not documented this monitoring.

The clinical record indicated that on the following day, registered staff #610 was informed by a PSW that the resident was complaining of pain on the identified body part. When the resident was approached the resident indicated "it hurts", registered staff #610 noted an injury on the affected body part, the resident was complaining of pain and guarding the identified body part. An assessment was documented, the residents refusal of treatment was documented and the resident's Substitute Decision Marker (SDM) was contacted. Resident #002's SDM visited in the morning of the following day, and reported that the resident told them about the incident and that the identified body part hurt. Registered staff #610 reported that the resident's physician had been contacted about the injury and an order was received to x-ray the identified body part. Based on the resident's account of how the injury had occurred the SDM requested that the resident be sent to the hospital.
The resident returned from hospital and it was confirmed by staff at the hospital that the resident had sustained an injury.

The licensee failed to protect resident #002 from abuse when they:
1. Failed to ensure that all staff providing direct care to residents received required training in behaviour management.
2. Failed to ensure that the resident's plan of care provided clear directions to staff providing care related to the strategies that were to be implemented when the resident demonstrated responsive behaviours.
3. Failed to ensure that the resident was assessed and the strategies were developed to manage responsive behaviours being demonstrated by the resident.
4. Failed to ensure that registered staff monitored the care being provided to the resident when they were aware that the resident was demonstrating responsive behaviours.

(PLEASE NOTE: The above noted non-compliance related to protection from abuse was identified while completing an inspection of Complaint #02488-16, Critical Incident #023360-16 and Critical Incident #023787-16) [s. 19. (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. 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 ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to the behaviours, where possible and action were taken to respond to the needs of the resident, including assessment, reassessments and interventions and that the resident's responses to interventions were documented.
a) Staff and the clinical record confirmed that resident #002 demonstrated responsive behaviours.
i) Personal Support Worker (PSW) documentation in the computerized clinical record, for an identified month in 2016, indicated that the resident demonstrated 5 types of responsive behaviours. The documentation indicated that there were 65 episodes of the above noted behaviours demonstrated during this month. A review of clinical notes made by registered nursing staff indicated that 54 of the 65 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #002, no attempt to assess the behaviours, no attempt to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
ii) Personal Support Worker (PSW) documentation in the computerized clinical record for the following month, indicated that the resident continued to demonstrate six types of responsive behaviours. The documentation indicated that there were 54 episodes of the above noted behaviours demonstrated in this month. A review of clinical notes made by

registered nursing staff indicated that 49 of the of the 54 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed there were no other source of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #002, no attempt to assess the behaviours, no attempt to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
iii) A review of the Medication Administration (MAR) for an identified month in 2016, indicated that resident #002 demonstrated responsive behaviour related to a specific type of care 49 times. A review of the clinical record indicated that registered staff who were responsible for providing this care had not made a clinical note for 43 of the 49 episodes when the resident demonstrated this behaviour and there were no indications of what actions staff took in response to the behaviour or what strategies were going to be implemented to manage this behaviour. A review of the MAR for the following month indicated that the resident continued to demonstrate this responsive behaviour and 34 episodes were identified in the MAR. A review of the clinical record indicated that registered staff who were responsible for providing this care had not made a clinical note for 28 of the 34 episodes of this behaviour, there were no indications what actions staff took in response to this behaviour or what strategies were going to be implemented to manage this behaviour. The DOC confirmed that staff had not documented the specific circumstances around this behaviour, what may have triggered the behaviour, what actions were taken to manage the behaviour, had not developed strategies to manage this behaviour and had not reassess the plan of care in relation to this behaviour.
(PLEASE NOTE: The above noted non-compliance related to the management of responsive behaviours was identified while completing an inspection of Complaint #024288-16, Complaint # 023756-16, Critical Incident #023360-16 and Critical Incident #023787-16)

b) Staff and the clinical record confirmed that resident #001 demonstrated responsive behaviours.
i) Personal Support Worker (PSW) documentation in the computerized clinical record, for an identified mouth in 2016, indicated that the resident demonstrated four types of responsive behaviours. The documentation indicated that there were 25 episodes of the above noted behaviours demonstrated in this month. A review of clinical notes made by registered nursing staff indicated that 23 of the 25 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the

specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #001, no attempt to assess the behaviours, no attempt to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
ii) Personal Support Worker documentation in the computerized record, for the following month indicated that the resident continued to demonstrate four types of responsive behaviours. The documentation indicated that there were 14 episodes of the above noted behaviours demonstrated in this month. A review of clinical notes made by registered nursing staff indicated that 11 of the 14 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed that there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #001, no attempt to assess the behaviours, no attempt to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
iii) A review of an identified Medication Administration (MAR) indicated that resident #001 demonstrated responsive behaviours related to a specific type of care 30 times. A review of the clinical record indicated that registered staff who were responsible to provide this care had not made a clinical note for 24 of the 30 episodes and there was not documentation related to the actions staff took to manage this behaviour. A review of the MAR for the following month indicated that the resident continued to demonstrate this responsive behaviour and 32 episodes were identified in the clinical record. The DOC confirmed that staff had not documented the specific circumstances around this behaviour, what may have triggered the behaviour, had not documented what actions were taken to manage the behaviour and had not reassess the plan of care in relation to this responsive behaviour.

(PLEASE NOTE: The above noted non-compliance related to the management of responsive behaviours was identified while completing an inspection of Complaint #023756-16 and #028674-16)

c) Resident #005 was identified as demonstrating a specific responsive behaviour. Clinical notes made by registered staff indicated that in the first 22 days of an identified

month in 2016 this behaviour was exhibited 10 times.
i) The Acting Director of care and the clinical record confirmed that there had been no attempt to document the specific issues during each episode of the identified behaviour and there was no indication in the clinical record that triggers for this behaviour had been identified.
ii) A review of the clinical record, specifically the documents the home used to provide direction for staff in the provision of care to the resident, confirmed that strategies were not developed for staff to implement in order to respond to the identified behaviour. Two documents reviewed, both the Care Plan and the Kardex developed for resident #005 indicated the identified behaviour was a trigger for other responsive behaviours being demonstrated by the resident and neither of these documents provided strategies for staff to implement in order to manage the identified behaviour.
iii) The Acting Director of Care and clinical documentation confirmed that actions were not taken to respond to the needs of resident #005 when it was confirmed that behavioural episodes were not being documented by personal support workers, the identified behaviour was not assessed, registered staff did not reassess this responsive behaviour when resident # 005 continued to demonstrate the behaviour and the resident's response to action taken by staff when the behaviour was demonstrated were not documented.

(PLEASE NOTE: The above noted non-compliance related to the management of responsive behaviour was identified while completing an inspection of Complaint # 024059-16) [s. 53. (4)]

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
The clinical record indicated that on an identified date, resident #001's family reported that the resident had changes in their skin integrity. Documentation made by registered staff confirmed that changes in the resident's skin integrity were present for five days following return from hospital. Registered staff #606 confirmed during an interview on August 19, 2016, that when a resident demonstrated alteration in their skin integrity staff were to complete an assessment located in the assessment tab of the computerized record. After completing a review of the clinical record staff # 606 confirmed that an assessment of resident #001 related to changes in their skin integrity had not been completed.
(PLEASE NOTE: The above noted non-compliance related to an assessment of the resident's skin was identified while completing an inspection of Complaint #023756-16 and Critical Incident # 023352-16) [s. 50. (2) (b) (i)]

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 and ensuring that all residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Care was not provided to resident #001 as specified in the plan of care related to foot care. The Director of Care, registered staff # 614 and the clinical record confirmed that resident #001's plan of care directed that the resident was to receive foot care from the foot care nurse every six weeks. The plan of care also specified that the foot care nurse was to document the treatment provided in a "Foot Care" progress note every six weeks. Registered staff # 614 confirmed that this care was not provided when documentation indicated the resident had not receive foot care during an identified nine week period. Registered staff #614 and clinical documentation indicated that foot care had not been provided to the resident during a second identified 17 week period of time. Registered

staff #614 confirmed that they were unable to recall if foot care had been provided to the resident during this period of time.
(PLEASE NOTE: The above noted non-compliance related to the provision of foot care was identified while completing an inspection of Complaint #028674-16) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.
a) Documentation by registered staff indicated that resident #001's care needs changed when it was identified that the resident had experienced a worsening of mood.
Data collected and documented during the Minimum Data Set (MDS) completed on an identified date, indicated that the resident presented with five indicators of alteration in mood. The associated Resident Assessment Protocol (RAP) indicated there was no requirement for a referral at the time this data was analyzed and staff did not document any rationale or care plan decisions.
Data collected on the subsequent MDS indicated the resident presented with 13 indicators of alteration in mood which represented a worsening of the resident's mood. Staff who completed this MDS also indicated that there had been no change in the resident's mood from the previous 90 days.
The Director of Care and the clinical record confirmed that staff had not developed a care focus related to mood, there was no indication that the change in the resident's mood indicators had been assessed and there was no indication that interventions had been considered or implemented when documentation identified that the residents mood indicators had deteriorated.
(PLEASE NOTE: The above noted non-compliance related responsive behaviours was identified while completing an inspection of Complaint #028674-16)

b) Changes in resident #001's skin integrity were noted in the clinical record on an identified date, when the resident's family member reported these changes in skin integrity. Documentation made by registered staff confirmed that this change in skin integrity was observed for five consecutive days. During an interview registered staff # 606 reviewed the plan of care and confirmed that revisions to the resident's care plan had not been made, there was no indication that the resident was identified as having a change in their skin integrity and there were no interventions identified for the management of this change in the resident's skin integrity.
(PLEASE NOTE: The above noted non-compliance related to an assessment of the resident's skin was identified while completing an inspection of Complaint #023756-16 and Critical Incident # 023352-16) [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 and ensuring that care set out in the resident's plan of care is provided as specified in the plan and the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was bathed, at a minimum, twice a week.
The Director of Care and the clinical record confirmed that for the week of September 7 to 14, 2016, the resident received one bath, for the week of September 14 to 20 the resident received one bath and for the week of September 20 to 27, 2016, the resident received one bath. For scheduled baths not provided staff documented that the resident was not available and/or the resident refused the schedule bath. The clinical record confirmed that there was no documentation to indicate that the resident was offered or had been provided a bath on a day other than their scheduled bath day during the above noted periods of time.
(PLEASE NOTE: The above noted non-compliance related responsive behaviours was identified while completing an inspection of Complaint #028674-16) [s. 33. (1)]

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 and ensuring that each resident is bathed, at a minimum, twice weekly by the method of their choice or more frequently if determined by the resident's hygiene requirements, unless contraindicated by a medical condition., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques during resident transfers.

1. Resident #001's plan of care indicated the resident required two persons and the use of a mechanical lift for transfers. The plan of care indicated the resident used a specific sling when being transferred. Resident #001's SDM reported to the home that staff who transferred the resident on an identified date, had not applied the sling appropriately and lifted the resident. Information collected during the home's investigation into this incident confirmed that staff #608 had not received training on the use of the specific sling designated for use by resident #001 and was not familiar with the routine of care for this resident. During interview conducted by the home, staff #608 and staff #605 confirmed that the sling had not been applied properly and that the resident had to be quickly moved and transferred. During a telephone interview with staff #608 they confirmed that the sling was not applied correctly when they and staff #605 transferred the resident on the identified date. The Administrator provided the manufacturers directions for the application of the sling which indicated the proper application of the specific sling. Staff did not use safe transferring techniques when they failed to follow manufacturer's directions for the application of the sling used to transfer resident #001 on the identified date, or the directions posted above the resident's bed for the application of the specified sling.

(PLEASE NOTE: The above noted non-compliance related to safe resident transfer was identified while completing an inspection of Complaint #023756-16 and Critical Incident # 022369-16)

2. Staff did not use safe transferring devices to transfer resident #004, based on the directions in the resident's plan of care, assessments completed by physiotherapy and the resident's functional abilities.
On an identified date in 2016 Personal Support Worker (PSW) staff #611 and #613 transferred the resident using a mechanical lift that required the resident to be able to stand. The resident was unable to bear weight in order to stand, which was identified as a requirement for the use of the mechanical lift used by staff and the resident's legs buckled as staff lowered the resident to the floor. Registered staff #610 was called, assessed the resident, contacted the resident's physician to report the incident and suggested an x-ray be considered based on their assessment.
Resident #004's plan of care indicated that nine months prior to the above incident, a care intervention was initiated that directed that the resident required activities of daily living assistance from two persons with the use of a mechanical lift for transfers. The six most recent physiotherapy assessments indicated that the resident required the use of a mechanical lift for transfers and was not able to bear weight in order to stand. Registered staff # 610 was interviewed by the home following this incident and confirmed that they believed the resident to be unable to bear weight in order to stand.
Staff transferring resident #004 on the identified date did not use safe lift and transferring techniques when a mechanical that required the resident to come to a standing position was used to transfer the resident when the resident's plan of care indicated the resident did not have the physical capabilities required to use this type of mechanical lift.

(PLEASE NOTE: The above noted non-compliance related to safe transfers was identified while completing an inspection of CIS # 02484-16) [s. 36.]

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 and ensuring that all staff use safe transferring and positioning devices or techniques during resident transfers, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the area of behaviour management annually, in accordance with O.Reg. 79/10, s. 221(2)

Documents provided by the home, at the time of this inspection, confirmed that 13 of 32 staff who provided direct care to residents in 2015 had not received training in the area of behaviour management in 2015. [s. 76. (7) 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 and ensuring that all staff who provide direct care to residents receive training in the area of behaviour management annually, to be implemented voluntarily.

WN #8: 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 failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol or procedure that the plan, policy, protocol or procedure was complied with.
a) Staff failed to comply with the home's policy "Skin Risk Assessment and Head-To-Toe Skin Assessment", located in the Resident Care and Service Manual, identified as #RCS G-35-05 with a date of July 15, 2015.
This policy directed that "the risk of skin breakdown will be assessed on admission, quarterly, and whenever there is a change in the resident's health status that affects skin integrity" and "registered staff assess and document the assessment including changes to the care plan as required and initiates appropriate interventions".
The clinical record indicated that resident #001's family reported to staff on an identified date, that the resident had changes in their skin integrity. Registered staff # 606 confirmed during an interview on August 19, 2016, that this policy had not been complied with when an assessment of this change in the resident's skin integrity was not initiated,

the care plan had not been updated and there were no interventions identified for the care and treatment of the resident's skin.
(PLEASE NOTE: The above noted non-compliance related to an assessment of the resident's skin was identified while completing an inspection of Complaint #023756-16 and Critical Incident # 023352-16)
b) Staff failed to comply with the home's policy "Transfers", identified as #RCS E-20 with a revised date of February 24, 2015.
This policy directed that residents will be assessed for ability to transfer by Registered Staff or Physiotherapist, all staff will be required to have training and practice on all mechanical lifts yearly, all residents will be assessed for appropriate lifts and slings by a member of the home's Safe Lifts and Transfer Team and the slings must be applied following directions.
Staff did not comply with the above noted directions when resident #001 was transferred on an identified date, and when resident #004 was transferred on an identified date.
i) A review of the clinical record and the Acting Director of Care confirmed that an assessment by registered staff or the physiotherapist of resident #001 and resident #004 related to transfers had not been completed in accordance with the directions in the policy. Staff #609 confirmed that although the policy directed that all residents will be assessed for appropriate lifts and slings by a member of the home's Safe Lifts and Transfer Team, this team is not operational in the home and the policy was not complied with.
ii) The Administrator confirmed that an investigation of a transfer incident that occurred on an identified date confirmed that staff # 608 and staff #605 did not comply with the home's policy when they did not apply the transfer sling used for resident #001 according to the directions printed above the resident's bed or the directions of the manufacturer for the application of this specific transfer sling before completing a transfer.
iii) Documents provided by the home and staff # 609 confirmed that the above noted policy was not complied with when training records for 2015 indicated that 41 of 62 staff had not received training and practice on all mechanical lifts in 2015.

(PLEASE NOTE: The above noted non-compliance related to an assessment of the resident's skin was identified while completing an inspection of Complaint #023756-16 and Critical Incident # 022369-16 and Critical Incident # 024848-16) [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of a sudden unexpected death.
Resident #003's clinical record indicated that on an identified date, the resident demonstrated distress and became unresponsive. Staff in attendance responded to this situation and emergency medical services were contacted. Although staff continued to respond to this situation, the resident remained unresponsive throughout this time and when emergency medical services personnel arrived at the home they identified the resident as having no vital signs. The Acting Director of Care confirmed that the home did not notify the Ministry of Health and Long Term Care of the sudden and unexpected death of the resident.

(PLEASE NOTE: The above noted non-compliance related to reporting a sudden death was identified while completing an inspection of Complaint #023756-16) [s. 107. (1) 2.]

Issued on this 2nd day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2016_205129_0011
Log No. / Registre no:	022369-16, 023352-16, 023360-16, 023756-16, 023787-16, 024059-16, 024288-16, 024848-16, 027845-16, 028674-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 22, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	ORCHARD TERRACE CARE CENTRE 199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Agnes Jankowski

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is directed to take the following measures to ensure that all residents including resident #002 are protected from abuse by anyone.
1. Provide the required mandatory training to all staff who provide direct care to residents, in the area of behaviour management.
2. Review the plans of care for all residents demonstrating responsive behaviours to ensure that those plans of care provide clear direction to staff related to the strategies to be implemented when a resident demonstrates responsive behaviours.
3. Ensure the care being provided to residents who demonstrate responsive behaviours is monitored by registered staff.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the actual harm that resident #002 experienced, the scope of one isolated incident, and the Licensee's history of non-compliance with a Compliance Order on August 25, 2015, related to the licensee's duty to protect residents from abuse and neglect.

2. In accordance with the definition of physical abuse identified in the Long Term Care Homes Act, 2007, Ontario Regulation 79/10 resident #002 was physically abused by Personal Support Worker (PSW) staff # 603 and PSW staff # 607 when physical force was used in order to provide care to resident #002 and the following day the resident reported that they had sustained an injury.
A review of information provided by the home indicated that on an identified date, PSW staff # 607 and PSW staff # 603 approached resident #002 to provide care. PSW staff #607 described the resident as demonstrating

responsive behaviours. PSW staff #607 indicated that this was the second time they had approached the resident in order to provide care.
During an interview PSW staff #603 confirmed that when they were providing care on the identified date, the resident was in bed, the bed rails were raised and the resident was demonstrating responsive behaviours. This staff person went on to explain that they restrained the resident in order to provide care.
PSW staff # 603 confirmed that they continued to provide care to the resident while the resident was demonstrating responsive behaviours. This staff person confirmed that they had not reported the resident's behaviour to the charge nurse.
During an interview PSW staff # 607 confirmed that while they were trying to provide care to the resident on the identified date, the resident continued to demonstrate responsive behaviours. This staff person indicated they continued to provide care to the resident while the resident was demonstrating responsive behaviours.
During an interview staff # 604 confirmed that at on the following day, resident #002 approached them, they noted that the resident appeared to be in pain, reported an incident and an injury. Staff # 604 immediately reported this to registered staff #606.
During an interview registered staff #606 confirmed that they were told by staff #604 that the resident had reported that they had been injured. They assessed the resident, the resident was able to move the identified body part without difficulty and the resident did not appear to be in pain. When asked if they continued to monitor the resident related to this reported injury they indicated they had, but they had not documented this monitoring.
The clinical record indicated that on the following day, registered staff #610 was informed by a PSW that the resident complained of pain at the identified body part. When the resident was approached they indicated that the identified body part hurt, registered staff #610 noted an injury on the identified body part, the resident was complaining of pain and guarding the identified body part. An assessment was documented, the residents refusal of treatment was documented and the resident's Substitute Decision Marker (SDM) was contacted.
Resident #002's SDM visited in the morning of the following day, and reported that the resident told them of the incident and indicated they were experiencing pain at identified body part. Registered staff #610 reported that the resident's physician had been contacted about the injury and an order was received to x-ray the identified body part. Based on the resident's account of how the injury had occurred the SDM requested that the resident be sent to the hospital.

The resident returned from hospital where it was confirmed the resident had sustained an injury to an identified body part. The two PSWs involved in this incident did not work in the home at the time this inspection was conducted.

The licensee failed to protect resident #002 from abuse when they:
1. Failed to ensure that all staff providing direct care to residents received training in behaviours management.
2. Failed to ensure that the resident's plan of care provided clear directions to staff providing care of the strategies that were to be implemented when the resident demonstrated responsive behaviours.
3. Failed to ensure that the resident was assessed and the strategies were developed to manage responsive behaviours being demonstrated by the resident.
4. Failed to ensure that registered staff monitored the care being provided to the resident when they were aware that the resident was demonstrating responsive behaviours.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 06, 2017

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. 53. (4) The licensee shall ensure 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. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee is directed to:
1. Develop and implement a system for the documentation of responsive behaviours being demonstrated by residents that will facilitate the identification of possible behavioural triggers.
2. Initiate a mechanism where the health care team will review responsive behaviours, develop strategies to manage those behaviours and ensure resident's responses to the implemented strategies are documented.
3. Ensure that assessments and reassessments for residents demonstrating responsive behaviours occur at intervals that are appropriate, based on the individual care needs of the resident and that these actions are documented.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for actual harm to resident's demonstrating responsive behaviours, the widespread scope of non-compliance identified for three of three residents reviewed, and the Licensee's history of non-compliance (Voluntary Plan of Correction) on February 6, 2014, related to actions not taken to respond to the needs of residents demonstrating responsive behaviours and a (Voluntary Plan for Correction) on September 23, 2016, related to behavioural triggers not identified and strategies not developed and implemented to respond to residents demonstrating responsive behaviours.

2. Staff and the clinical record confirmed that resident #001 demonstrated responsive behaviours.
i) Personal Support Worker (PSW) documentation in the computerized clinical record, for an identified month in 2016, indicated that the resident demonstrated four types of responsive behaviours. The documentation indicated that there were 25 episodes of the above noted behaviours demonstrated in this month. A review of clinical notes made by registered nursing staff indicated that 23 of the 25 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviours or actions taken to manage the responsive behaviours. The Director of Care (DOC) and the clinical record confirmed there were no other sources of documentation for these behaviours, that there had been no attempt to document the specific behaviours being demonstrated by resident #001, to assess the behaviours, to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
ii) Personal Support Worker documentation in the computerized record, for the following month, indicated that the resident continued to demonstrate four types of responsive behaviours. The documentation indicated that there were 14 episodes of the above noted behaviours demonstrated in this month. A review of clinical notes made by registered nursing staff indicated that 11 of the 14 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed that there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #001, to assess the behaviours, to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
iii) A review of the Medication Administration (MAR) for an identified month in 2016, indicated that resident #001 demonstrated responsive behaviours related to a specific type of care 30 times. A review of the clinical record indicated that registered staff who were responsible for providing this care had not made a clinical note for 24 of the 30 episodes of this responsive behaviour and there was not documentation related to the actions staff took to manage this behaviour. A review of the MAR for the following month indicated that the resident continued to demonstrate this responsive behaviour and 32 episodes

were identified in the clinical record. The DOC confirmed that staff had not documented the specific circumstances around this behaviour, what may have triggered the behaviour, what action were taken to manage the behaviour and had not reassess the plan of care in relation to this specific behaviour.

3. Staff and the clinical record confirmed that resident #002 demonstrated responsive behaviours.
i) Personal Support Worker (PSW) documentation in the computerized clinical record, for an identified month in 2016, indicated that the resident demonstrated five types of responsive behaviours. The documentation indicated that there were 65 episodes of the above noted behaviours demonstrated during this month. A review of clinical notes made by registered nursing staff indicated that 54 of the 65 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviours being demonstrated, an assessment of the behaviours or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #002, to assess the behaviours, to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
ii) Personal Support Worker (PSW) documentation in the computerized clinical record, for the following month, indicated that the resident continued to demonstrate five types of responsive behaviours. The documentation indicated that there were 54 episodes of the above noted behaviours demonstrated during this month. A review of clinical notes made by registered nursing staff indicated that 49 of the of the 54 behavioural episodes documented by PSWs did not have corresponding documentation by registered staff that identified the specific behaviour being demonstrated, an assessment of the behaviour or actions taken to manage the responsive behaviours. The Director of Care and the clinical record confirmed there were no other sources of documentation for these behaviours, there had been no attempt to document the specific behaviours being demonstrated by resident #002, to assess the behaviours, to identify possible triggers for the behaviours and the plan of care did not contain strategies to manage these behaviours.
iii) A review of the Medication Administration (MAR) for an identified month in 2016, indicated that resident #002 demonstrated a responsive behaviour related to a specific care area 49 times. A review of the clinical record indicated that registered staff who were responsible for providing this care had not made a

clinical note for 43 of the 49 episodes when the resident demonstrated this behaviour and there was no indications what actions staff took in response to this behaviour or what strategies were going to be implemented to manage this behaviour. A review of the MAR for the following month indicated that the resident continued to demonstrate this behaviour and 34 episodes were identified in the MAR. A review of the clinical record indicated that registered staff who were responsible to provide this care had not made a clinical note for 28 of the 34 episodes of this behaviour, there were no indications what actions staff took in response to this behaviour or what strategies were going to be implemented to manage this behaviour. The DOC confirmed that staff had not documented the specific circumstances around this behaviour, what may have triggered the behaviour, what action was taken to manage the behaviour, had not developed strategies to manage this behaviour and had not reassess the plan of care in relation to this behaviour.

4. Resident #005 was identified as demonstrating a responsive behaviour. Clinical notes made by registered staff indicated that in the first 22 days of an identified month in 2016 this behaviour was exhibited 10 times.
i) The Acting Director of Care and the clinical record confirmed that there had been no attempt to document the specific issues during each episode of the responsive behaviour and there was no indication in the clinical record that triggers for this behaviour had been identified.
ii) A review of the clinical record, specifically the documents the home used to provide direction for staff in the provision of care to the resident, confirmed that strategies were not developed for staff to implement in order to respond to the responsive behaviour. Two documents reviewed, both the Care Plan and the Kardex developed for resident #005 indicated the responsive behaviour was a trigger for other responsive behaviours being demonstrated by the resident and neither of these documents provided strategies for staff to implement in order to manage the behaviour.
iii) The Acting Director of Care and clinical documentation confirmed that actions were not taken to respond to the needs of resident #005 when it was confirmed that behavioural episodes were not being documented by personal support workers, the responsive behaviour had not been assessed, registered staff did not reassess this responsive behaviour when resident # 005 continued to demonstrate the behaviour and the resident's response to action taken by staff when the behaviour was demonstrated were not documented.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 06, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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