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 soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017	2017_668543_0006	019332-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET P.O. BOX 4000 COCHRANE ON P0L 1C0

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

VILLA MINTO
241 EIGHTH STREET P.O. BOX 280 COCHRANE ON P0L 1C0

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

TIFFANY BOUCHER (543), ALAIN PLANTE (620)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 18-22, 2017

One follow-up intake related to compliance order #001 from inspection report #2017_671684_0001 related to O.Reg. 79/10, s. 82 (1), was inspected during this Resident Quality Inspection (RQI).

Throughout the inspection, the Inspectors directly observed the delivery of care and services to residents in all home areas, reviewed resident health care records and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with The Chief Executive Officer (CEO)/Administrator, Director of Care (DOC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Recreational Therapist, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **4 VPC(s)**
- **3 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.O. 2007, c.8, 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 #001 was protected from neglect by the

licensee or staff in the home.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent Minimum Data Set (MDS) assessment. Inspector #543 reviewed this resident's MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Resident #001 was admitted to the home in 2014, at that time the resident did not have any areas of altered skin integrity. On September 21, 2017, Inspector #543 spoke with the resident's primary physician who verified that the resident's areas of altered skin integrity had developed while in the home.

The Inspector reviewed this resident's most recent care plan, specifically related to altered skin integrity which indicated that resident #001 had a history of areas of altered skin integrity. This resident's care plan identified two areas of altered skin integrity.

A) Skin and wound assessments not completed;

Inspector #543 reviewed resident #001's Skin and Wound assessments, for specific months in 2017. The Inspector reviewed 19 skin and wound care assessments and identified that 17 of the 19 or 89.5 per cent of the time, the skin and wound care assessments were either incomplete, inaccurate or not done at all.

Inspector #543 interviewed RN #102 who indicated that resident #001 had ongoing issues with areas of altered skin integrity. They verified that one of the resident's areas of altered skin integrity had worsened and that skin and wound care assessments including staging should be completed weekly by registered staff.

Inspector #543 reviewed with the DOC, the assessments, indicating that some assessments were either incomplete, inaccurate or not done at all. The DOC indicated that every resident with areas of altered skin integrity would have a skin and wound care assessment completed weekly in its entirety, which would include the location, size and stage (if applicable) of the area of altered skin integrity.

The Long-Term Care Homes Act (LTCHA), 2007, O. Reg. 79/10, section 50 (2)(b)(iv) stipulates that every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Please refer to WN #6 for details.

B) Documentation not completed;

Inspector #543 reviewed communication notes utilized to communicate concerns the staff have for the physician to address during rounds, which indicated that resident #001's area of altered skin integrity had worsened and registered staff requested the physician to assess the area and provide an order.

Inspector #543 reviewed resident #001's health care record for physician assessments related to this resident's areas of altered skin integrity. The Inspector was unable to locate any assessments completed or documented by the physician.

Inspector #543 interviewed the physician regarding assessments completed related to resident #001's areas of altered skin integrity who verified that they did not have separate assessments documented, that they relied on the nurses assessments.

The LTCHA, 2007, O. Reg. 79/10, section 30 (2), stipulates that licensee shall ensure that, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. Please refer to WN #7 for details.

C) Pain assessments;

Inspector #543 reviewed resident #001's health care record for pain assessments related to this resident's areas of altered skin integrity. The Inspector was unable to locate any assessments related to pain management.

The Inspector reviewed the home's "Pain Management Program (LTC-003)", last reviewed in February 2017. The program indicated that the purpose was that to maintain an interdisciplinary team approach to pain management that provided the resident with optimal comfort, dignity and quality of life. The program identified that each resident would have a formal pain assessment on admission and be reassessed on each

readmission, quarterly and whenever there was a significant change in their condition.

The Inspector reviewed the home's "Skin and Wound Care Program (LTC-003)", last reviewed in February 2017. The program identified that residents with a specific area of altered skin integrity would have a pain assessment completed and would be referred to a physician for effective management. All residents with areas of altered skin integrity would be reassessed with each dressing change at a minimum weekly by a registered staff member. The policy indicated that for areas with a specific staging, staff would consider pain management and for areas with a different specific staging proper pain management is required.

Inspector #543 interviewed the DOC, who verified that no pain assessments had been completed or documented for this resident, they indicated that this resident's areas of altered skin integrity as well as other medical factors would be indications for a pain assessment to be completed.

The LTCHA, 2007, O. Reg. 79/10, section 52 (2), stipulates that every licensee of a long-term care home shall ensure that when a resident's pain is not relived by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. Please refer to WN #8 for details. [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. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that either a physician or a registered nurse in the extended class, attends regularly at the home to provide services, including assessments.

A previous compliance order (CO) #001 was issued to the licensee on August 2, 2017, related to the licensee's failure to comply with O. Reg 79/10, section 82 from inspection report #2017_671684_0001. Although the licensee complied with the order, additional non-compliance was identified related to O. Reg. section 82 (1)(b).

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent MDS assessment. Inspector #543 reviewed this resident's MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Inspector #543 reviewed email correspondence which was provided to Inspectors #543 and #620 related to physicians in the home, which indicated the following:

a) that a family wrote with concerns that the home's physician had not been in the home for a period of time, this correspondence indicated that residents were being sent to the emergency department as a result of the physician not attending in the home regularly;
b) identified a lack of professionalism of physicians by not conducting regular visits to

the home, and the family choosing to bring their family (a resident in the home) to the emergency department for assessment as a result of concerns being ignored by physicians;
c) identified to the management team that residents were not being seen by a physician for at times, months on end and ignoring residents’ requests to be seen by a physician; and
d) the Administrator pointed out to their management team that they had discussed a lack of coverage from the home’s physicians for residents.

The email correspondence was reviewed from a time period between 2016 and 2017, which identified an ongoing concern related to the physician attending regularly at the home to provide services, including assessments.

Inspector #543 reviewed meeting minutes from the Family Council (FC) meetings, which identified that there "was still a concern" related to securing regular visits from the physician. The FC requested an update on the home securing regular visits from the physician.

On September 21, 2017, Inspector #543 interviewed the DOC, who verified that the physician was not in the home very often, and that at times a month would go by without the physician seeing the residents.

Inspector #543 interviewed the Administrator who stated that they had spoken to the physician with regards to their being neglectful of conducting regular assessment for their residents in the past. They verified that there had been numerous concerns brought forward by the DOC and many concerns from family and staff in the home and they indicated that the physician did not attend to the home on a regular basis as required. The Administrator indicated that they were aware that staff and family were forced to circumvent having a resident's health issues addressed by the physician, by bringing residents to the emergency department to deal with clinical matters that were not being addressed by the physician.

In an interview with the physician, Inspector #543 asked them how often they completed rounds on their assigned residents, to which they responded on a particular day each week. The Inspector then asked when was the last time they had assessed resident #001's areas of altered skin integrity, to which their response was the month previous. [s. 82. (1) (b)]

2. The licensee has failed to enter into an appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3).

Inspector #543 reviewed the "Attending Physician Services Agreement", dated on a specific date in 2016, between a physician and Lady Minto Hospital (the Corporation). Page eight of the document indicated that three signatures were required, from the Administrator, the Medical Director and the physician. Page nine of the document, Schedule "A", provided a description of the services required by the physician. The document noted that "The Physician agrees to devote the necessary time and attention to their Attending Physician position at Villa Minto and shall provide the following Services to the Corporation for each Resident whom the Physician is responsible for, for the duration of the Term of this Agreement, beginning on or before the specific date in 2016 (the "Services Commencement Date")." The Inspector identified that the agreement had not been signed by the three above mentioned individuals.

On November 29, 2017, Inspector #543 spoke with the Administrator who verified that the agreement had not been signed. [s. 82. (4)]

Additional Required Actions:

CO # - 002, 003 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. 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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As identified in O. Reg. 79/10, s.50 (1) the licensee shall have a skin and wound program, and s. 136 (1) the licensee shall ensure, as part of the medication management system, have a written policy developed in the home that provides for the ongoing drug identification, destruction and disposal.

A) Inspector #543 reviewed the home's "Skin and Wound Care Program (LTC-003)", last reviewed in February 2017. This program indicated that the home's skin care, risk assessment and wound care treatment plans are based on resident focused goals of pressure relief, improved or sustained skin integrity, comfort and mobility, infection prevention and healing and/or palliation. All residents with areas of altered skin integrity would be reassessed with each dressing change at a minimum weekly by a registered staff member. The physician would participate/consult weekly with registered staff regarding outcomes of treatments, refer to specialized consultation services as required and monitor, evaluate and document outcomes of treatments.

Inspector #543 reviewed resident #001’s health care record for physician assessments and orders related to this resident’s two areas of altered skin integrity. The Inspector was unable to locate any assessments or orders completed by the physician specifically related to resident #001’s areas of altered skin integrity.

Inspector #543 interviewed the physician regarding assessments completed related to resident #001’s areas of altered skin integrity who verified that they did not complete a separate assessment nor do they document. [s. 8. (1) (a),s. 8. (1) (b)]

2. On September 21, 2017, RPN #107 provided Inspector #620 a tour of the home's medication storage area. The RPN opened a locked stationary cabinet in the medication room. The Inspector observed narcotic medications unsecured within the locked stationary.

RPN #107, indicated that the narcotic medications could not be placed within the locked destruction container because it was too full.

Inspector #543 reviewed the home’s “Drug Destruction and Disposal policy (5-4)" which

identified that to ensure safe storage and accountability of all medication in the home including medications for administrations and those to be removed and destroyed provincially. All medications which become surplus are destroyed and disposed of, according to applicable legislation. The policy indicated that these medications would be retained in the double-locked wooden box, in the locked medication room, separate from those medications available for administration to a resident.

On September 21, 2017, Inspector #620 interviewed the DOC who indicated that the narcotic medications should not have been stored unlocked within the locked stationary cabinet. [s. 8. (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's Skin and Wound Care Program and Drug Destruction and Disposal Policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a written complaint was received regarding the care of a resident or the operation of the long-term care home it was immediately forwarded to the Director.

Inspector #543 reviewed email correspondence from the home that indicated on a date in 2016, whereby a resident's family member indicated their deep concern for their family related to lack of care provided to residents at the home. The correspondence also identified, that it had been brought to their attention that the physician had not attended the home in over a month. The family's request was that there be regular medical attention and that attending rounds be made on a regular basis to the residents of the home.

Inspector #543 failed to identify that the Director received any correspondence from the licensee related to the above mentioned complaint. In an interview the Administrator regarding the failure to notify the Director of the written complaint they indicated that they had not realized they had to report it, and was hoping they could have resolved the issue. [s. 22. (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 to ensure that when a written complaint is received regarding the care of a resident or the operation of the long-term care home it is immediately forwarded to the Director, to be implemented voluntarily.

WN #5: 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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director; specifically, misuse or misappropriation of a resident's money.

On September 19, 2017, during an interview with the DOC, they indicated to Inspector #620 that they were aware of an incident of financial abuse, involving resident #002. The DOC indicated that resident #002 was known to them, to have been financially abused.

Inspector #620 reviewed a progress note documented by the DOC on a date in 2016, which identified an incident of financial abuse.

Inspector #620 conducted a review of the home's critical incident submissions and was unable to identify a report to the Director related to the suspected financial abuse of resident #002.

Inspector #620 reviewed a document titled, "Zero Tolerance of Abuse and Neglect (LTC-105)" with a revision date of December 20, 2016. The documents described financial abuse as, "any misappropriation or misuse of a resident's money or property… Theft or unlawfully withholding a resident's money, pension, securities etc." The document also directed staff to report any suspicion of resident abuse to the Director immediately and indicated that, "The licensee Manager and staff are guilty of an offence if they fail to make a report."

In a subsequent interview, the DOC indicated that they had not reported the incident of suspected financial abuse to the Director because they were managing the incident internally. They indicated that in resident #002's case, actions were taken to address the suspected financial abuse. They indicated that they were aware that the incidents of financial abuse required immediate reporting to the Director. [s. 24. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any 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 was based to the Director; specifically, misuse or misappropriation of a resident's money, to be implemented voluntarily.

WN #6: 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent MDS assessment. Inspector #543 reviewed this resident's MDS

assessment, which identified that resident #001 had two areas of altered skin integrity.

The Inspector reviewed this resident's most recent care plan, specifically related to areas of altered skin integrity which indicated that resident #001 had a history of altered skin integrity. This resident's care plan identified two areas of altered skin integrity.

Inspector #543 reviewed resident #001's health care record, in the assessment tab in Point Click Care (PCC) which indicated that for a time period in 2017, 17 of the 19 or 89.5 per cent of the time, the skin and wound care assessments were either incomplete, inaccurate or not done at all.

The Inspector identified, but not limited to, the following:

a) 21 days there was no assessment completed for one of the areas of altered skin integrity.

b) nine days there was no assessment completed for one of the areas of altered skin integrity.

c) 21 days there was no assessment completed for one of the areas of altered skin integrity.

d) Four assessments that were completed did not identify the site that was being assessed.

e) Four assessments that were completed did not identify the staging of the area of altered skin integrity being assessed.

The Inspector reviewed the home's "Skin and Wound Care Program (LTC-003)", last reviewed in February 2017. This program indicated that the home's skin care, risk assessment and wound care treatment plans are based on resident focused goals of pressure relief, improved or sustained skin integrity, comfort and mobility, infection prevention and healing and/or palliation. All residents with areas of altered skin integrity would be reassessed with each dressing change at a minimum weekly by a registered staff member.

Inspector #543 interviewed RPN #103 who verified that resident #001 had two areas of altered skin integrity. The RPN indicated that one of the resident's areas of altered skin

integrity had worsened.

Inspector #543 interviewed RN #102 who indicated that resident #001 had ongoing issues with areas of altered skin integrity, and confirmed that one of the resident's areas of altered skin integrity had worsened. They indicated that Skin and Wound Care assessments and staging should be completed weekly by registered staff.

Inspector #543 reviewed with the DOC the skin and wound care assessments completed for a time period in 2017, indicating that some assessments were either incomplete, inaccurate or not done at all. The DOC indicated that every resident with skin integrity issues would have a staging assessment completed weekly in its entirety, which would include the location, the size and the stage (if applicable) of the area of altered skin integrity. [s. 50. (2) (b) (iv)]

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 a resident's pain is not relieved, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose and that when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent MDS assessment. Inspector #543 reviewed this resident’s MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Inspector #543 reviewed communication notes utilized to communicate concerns the staff have for the physician to address during rounds, which indicated that one of resident #001’s area of altered skin integrity had worsened and registered staff requested the physician to assess the area of altered skin integrity and provide an order.

The Inspector reviewed the home's "Skin and Wound care Program (LTC-003)", last reviewed in February 2017. This program indicated that the physician would participate/consult weekly with registered staff regarding outcomes of treatments, refer to specialized consultation services as required and monitor, evaluate and document outcomes of treatments.

Inspector #543 reviewed resident #001’s health care record for physician assessments related to this resident’s two areas of altered skin integrity. The Inspector was unable to locate any assessments completed or documented by the physician.

Inspector #543 interviewed RN #102 who indicated that they were unsure how often the physician had assessed resident #001’s area of altered skin integrity.

Inspector #543 interviewed the Administrator who verified that it had been an ongoing issue with regards to the physician not keeping documentation related to the care they provide to the residents.

Inspector #543 interviewed the physician regarding assessments completed related to resident #001’s areas of altered skin integrity who verified that they did not complete a separate assessment nor do they document. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent MDS assessment. Inspector #543 reviewed this resident's MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Inspector #543 reviewed resident #001's health care record for pain assessments related to this resident's areas of altered skin integrity. The Inspector was unable to locate any assessments related to pain management.

The Inspector reviewed the home's "Pain Management Program (LTC-003)", last reviewed in February 2017. The program indicated that the purpose was that to maintain an interdisciplinary team approach to pain management that provided the resident with optimal comfort, dignity and quality of life. The program identified that each resident would have a formal pain assessment on admission and be reassessed on each readmission, quarterly and whenever there was a significant change in their condition. The program identified that residents with areas of altered skin integrity would have a pain assessment completed and would be referred to a physician for effective management.

Inspector #543 interviewed the DOC, who verified that no pain assessments had been completed or documented for this resident, they indicated that this resident's areas of altered skin integrity as well as other medical factors would be indications for a pain assessment to be completed. [s. 52. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations; specifically, copies of the inspection reports from the past two years for the long-term care home.

On September 18, 2017, during a tour of the home Inspector #620 observed that the home only had four inspection reports posted. The posted inspection reports included #2016_428628_0010, #2016_428628_0011, #2016_428628_0007, and #2015_401616_0019.

A review of inspection reports served to the home for the last two years revealed that the following reports were not posted:
-Report #2017_671684_0001 served to the home on August 02, 2017,
-Report #2017_509617_0013 served to the home on July 11, 2017,
-Report #2016_429642_0012 served to the home on October 14, 2016, and
-Report #2016_507628_0016 served to the home on September 19, 2016.

Inspector #620 reviewed a document titled, "Mandatory Information Required to be Posted Checklist" (no Date), under item number 19 the document listed, "Copy of inspection reports for the last two years." The document indicated that the item was to be posted in the, "Far Hallway 1st board."

Inspector #620 interviewed the DOC who was asked to show the Inspector where the home posted the public inspection reports issued to the home. They escorted the Inspector to a bulletin board in a common area of the home. Four reports were observed to be posted. The Inspector asked if the reports posted represented two years of inspection reports; the DOC indicated, "no" and that they were unaware that the home was required to post two years of inspection reports. [s. 79. (3) (k)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

At 1342 hours on September 19, 2017, Inspector #620 and #543 observed a medication cart unlocked and unattended when they entered the home. The Inspectors observed five residents in proximity to the unlocked medication cart, which remained unlocked until the Inspector addressed the concern with the DOC.

On September 20, 2017, from 0958 hours to 1053 hours, Inspector #620 observed three residents seated approximately 2.5 meters from an unlocked and unattended medication cart.

Inspector #620 interviewed RPN #104, RPN #107, and RN #102 who all indicated that medication carts were to be locked when unattended.

On September 21, 2017, Inspector #620 interviewed the DOC about the observation of the unlocked medication carts. The DOC indicated that the medication carts were to be locked when unattended. They indicated that the home's policy "Pharmacy Policy & Procedure Manual for LTC Homes-Storage of Monitored Medications-6-4." required all medication carts to be locked when unattended. [s. 129. (1) (a)]

Issued on this 18th day of December, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543), ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2017_668543_0006
Log No. / No de registre :	019332-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 15, 2017
Licensee / Titulaire de permis :	THE LADY MINTO HOSPITAL AT COCHRANE 241 EIGHTH STREET, P.O. BOX4000, COCHRANE, ON, P0L-1C0
LTC Home / Foyer de SLD :	VILLA MINTO 241 EIGHTH STREET, P.O. BOX280, COCHRANE, ON, P0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Chatelain

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

Order / Ordre :

The licensee shall develop, submit and implement a plan that includes a detailed description of how the licensee will ensure compliance related to all aspects of section 19 (1) of the Act. This plan is to include, but is not limited to:

1-Developing and implementing a system to ensure that resident #001's skin and wound care assessments are completed, as per the home's policy and according to O. Reg. 79/10, section 50;

2-Developing and implementing a plan to ensure that the following home's policies are complied with according to O. Reg. 79/10, section 8 (1)(b), by staff and Physicians in the home:

a) Skin and Wound care Program (LTC-003), last reviewed in February 2017,
b) Pain Management Program (LTC-003), last reviewed in February 2017, and

3- Developing and implementing a plan to ensure that for every resident (including new admissions) a formal pain assessment is completed on admission, and reassessed on readmission, quarterly and whenever their condition changes.

This plan shall be submitted to Tiffany Boucher, Long-Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133 or emailed to SudburySAO.moh@ontario.ca.

This plan must be submitted by December 29, 2017 and fully implemented by January 31, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from neglect by the licensee or staff in the home.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #001 was identified as having a worsening area of altered skin integrity

through their most recent Minimum Data Set (MDS) assessment. Inspector #543 reviewed this resident's MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Resident #001 was admitted to the home in 2014, at that time the resident did not have any areas of altered skin integrity. On September 21, 2017, Inspector #543 spoke with the resident's primary physician who verified that the resident's areas of altered skin integrity had developed while in the home.

The Inspector reviewed this resident's most recent care plan, specifically related to altered skin integrity which indicated that resident #001 had a history of areas of altered skin integrity. This resident's care plan identified two areas of altered skin integrity.

A) Skin and wound assessments not completed;

Inspector #543 reviewed resident #001's Skin and Wound assessments, for specific months in 2017. The Inspector reviewed 19 skin and wound care assessments and identified that 17 of the 19 or 89.5 per cent of the time, the skin and wound care assessments were either incomplete, inaccurate or not done at all.

Inspector #543 interviewed RN #102 who indicated that resident #001 had ongoing issues with areas of altered skin integrity. They verified that one of the resident's areas of altered skin integrity had worsened and that skin and wound care assessments including staging should be completed weekly by registered staff.

Inspector #543 reviewed with the DOC, the assessments, indicating that some assessments were either incomplete, inaccurate or not done at all. The DOC indicated that every resident with areas of altered skin integrity would have a skin and wound care assessment completed weekly in its entirety, which would include the location, size and stage (if applicable) of the area of altered skin integrity.

The Long-Term Care Homes Act (LTCHA),2007, O. Reg. 79/10, section 50 (2) (b)(iv) stipulates that every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the

registered nursing staff, if clinically indicated. Please refer to WN #6 for details.

B) Documentation not completed;

Inspector #543 reviewed communication notes utilized to communicate concerns the staff have for the physician to address during rounds, which indicated that resident #001's area of altered skin integrity had worsened and registered staff requested the physician to assess the area and provide an order.

Inspector #543 reviewed resident #001's health care record for physician assessments related to this resident's areas of altered skin integrity. The Inspector was unable to locate any assessments completed or documented by the physician.

Inspector #543 interviewed the physician regarding assessments completed related to resident #001's areas of altered skin integrity who verified that they did not have separate assessments documented, that they relied on the nurses assessments.

The LTCHA, 2007, O. Reg. 79/10, section 30 (2), stipulates that licensee shall ensure that, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. Please refer to WN #7 for details.

C) Pain assessments;

Inspector #543 reviewed resident #001's health care record for pain assessments related to this resident's areas of altered skin integrity. The Inspector was unable to locate any assessments related to pain management.

The Inspector reviewed the home's "Pain Management Program (LTC-003)", last reviewed in February 2017. The program indicated that the purpose was that to maintain an interdisciplinary team approach to pain management that provided the resident with optimal comfort, dignity and quality of life. The program identified that each resident would have a formal pain assessment on admission and be reassessed on each readmission, quarterly and whenever there was a significant change in their condition.

The Inspector reviewed the home's "Skin and Wound Care Program (LTC-003)",

last reviewed in February 2017. The program identified that residents with a specific area of altered skin integrity would have a pain assessment completed and would be referred to a physician for effective management. All residents with areas of altered skin integrity would be reassessed with each dressing change at a minimum weekly by a registered staff member. The policy indicated that for areas with a specific staging, staff would consider pain management and for areas with a different specific staging proper pain management is required.

Inspector #543 interviewed the DOC, who verified that no pain assessments had been completed or documented for this resident, they indicated that this resident's areas of altered skin integrity as well as other medical factors would be indications for a pain assessment to be completed.

The LTCHA, 2007, O. Reg. 79/10, section 52 (2), stipulates that every licensee of a long-term care home shall ensure that when a resident's pain is not relived by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. Please refer to WN #8 for details.

The decision to issue a compliance order was based on actual harm to residents' health and safety, the home continues to have on-going non-compliance related to this area of the legislation. Although the scope was isolated, there was a history of previous non-compliance identified in the form of Compliance Orders for inspections #2016_507628_0016 and #2015_380593_0001.

(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_671684_0001, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;
(b) attends regularly at the home to provide services, including assessments; and

(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Order / Ordre :

The licensee shall develop prepare, submit and implement a plan that will include, but is not limited to, identifying a schedule that will ensure that either a physician or a registered nurse in the extended class, attends regularly at the home to provide services, including assessments.

This plan shall be submitted to Tiffany Boucher, Long-Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133 or emailed to SudburySAO.moh@ontario.ca.

This plan must be submitted by December 29, 2017 and fully implemented by January 31, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that either a physician or a registered nurse in the extended class, attends regularly at the home to provide services, including assessments.

A previous compliance order (CO) #001 was issued to the licensee on August 2,

2017, related to the licensee's failure to comply with O. Reg 79/10, section 82 from inspection report #2017_671684_0001. Although the licensee complied with the order, additional non-compliance was identified related to O. Reg. section 82 (1)(b).

Resident #001 was identified as having a worsening area of altered skin integrity through their most recent MDS assessment. Inspector #543 reviewed this resident's MDS assessment, which identified that resident #001 had two areas of altered skin integrity.

Inspector #543 reviewed email correspondence which was provided to Inspectors #543 and #620 related to physicians in the home, which indicated the following:

a) that a family wrote with concerns that the home's physician had not been in the home for a period of time, this correspondence indicated that residents were being sent to the emergency department as a result of the physician not attending in the home regularly;
b) identified a lack of professionalism of physicians by not conducting regular visits to the home, and the family choosing to bring their family (a resident in the home) to the emergency department for assessment as a result of concerns being ignored by physicians;
c) identified to the management team that residents were not being seen by a physician for at times, months on end and ignoring residents' requests to be seen by a physician; and
d) the Administrator pointed out to their management team that they had discussed a lack of coverage from the home's physicians for residents.

The email correspondence was reviewed from a time period between 2016 and 2017, which identified an ongoing concern related to the physician attending regularly at the home to provide services, including assessments.

Inspector #543 reviewed meeting minutes from the Family Council (FC) meetings, which identified that there "was still a concern" related to securing regular visits from the physician. The FC requested an update on the home securing regular visits from the physician.

On September 21, 2017, Inspector #543 interviewed the DOC, who verified that the physician was not in the home very often, and that at times a month would

go by without the physician seeing the residents.

Inspector #543 interviewed the Administrator who stated that they had spoken to the physician with regards to their being neglectful of conducting regular assessment for their residents in the past. They verified that there had been numerous concerns brought forward by the DOC and many concerns from family and staff in the home and they indicated that the physician did not attend to the home on a regular basis as required. The Administrator indicated that they were aware that staff and family were forced to circumvent having a resident's health issues addressed by the physician, by bringing residents to the emergency department to deal with clinical matters that were not being addressed by the physician.

In an interview with the physician, Inspector #543 asked them how often they completed rounds on their assigned residents, to which they responded on a particular day each week. The Inspector then asked when was the last time they had assessed resident #001's areas of altered skin integrity, to which their response was the month previous.

The decision to issue a compliance order was based on actual harm to residents' health and safety, the home has had one or more non-compliance related to this area of the legislation. Although the scope was isolated there was a history of previous non-compliance identified for inspection #2015_401616_0019 a Voluntary Plan of Correction and #2017_671684_0001 a Compliance Order.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Order / Ordre :

The licensee shall ensure that for every physician or registered nurse in the extended class, they enter into the appropriate written agreement under section 83 or 84, and that the agreement is signed.

Grounds / Motifs :

1. The licensee has failed to enter into an appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3).

Inspector #543 reviewed the "Attending Physician Services Agreement", dated on a specific date in 2016, between a physician and Lady Minto Hospital (the Corporation). Page eight of the document indicated that three signatures were required, from the Administrator, the Medical Director and the physician. Page nine of the document, Schedule "A", provided a description of the services required by the physician. The document noted that "The Physician agrees to devote the necessary time and attention to their Attending Physician position at Villa Minto and shall provide the following Services to the Corporation for each Resident whom the Physician is responsible for, for the duration of the Term of this Agreement, beginning on or before the specific date in 2016 (the "Services Commencement Date")." The Inspector identified that the agreement had not been signed by the three above mentioned individuals.

On November 29, 2017, Inspector #543 spoke with the Administrator who verified that the agreement had not been signed.

The decision to issue a compliance was order was based on Minimal harm or Potential for Actual Harm to residents' health and safety, although the scope was isolated the home had one or more un-related non-compliance in the last three years. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Tiffany Boucher

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