Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2014	2014_360111_0022	O-000843-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

LYNDA BROWN (111), AMANDA NIXON (148), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553), SAMI JAROUR (570), WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 5-8, 11-14, 2014

During this inspection, a follow-up (log#000324-14), 3 critical incident reports (log#000358-14, 000604-14 & 000818-14) and 1 complaint (log#000919-14) were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Unit Managers, Human Resources Manager, Physiotherapist, Residents, Families, Resident Council President, Family Council President, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Coordinator of Nursing Services, and Manager of Resident, Food Service Aides, and Family Services.

During the course of the inspection, the inspector(s) Toured the home, Reviewed health care records of resident, observed meal services, reviewed meeting minutes (for Resident & Family Council, and Infection Prevention & Control Committee), reviewed immunization/screening records for residents & staff, reviewed the homes policies (Infection Prevention and control, weight changes, falls prevention, restraints, preventative maintenance, housekeeping services, pharmacy medication procedures).

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. Related to log#000358-14:

The licensee has failed to ensure that procedures are developed and implemented to ensure that HVAC systems are inspected at least every six months by a certified individual.

A critical incident report(CI) was received on a specified date for a fire in an exhaust fan that occurred on a specified unit. The CI indicated procedures would be developed and implemented to increase the frequency of inspections as part of the preventative maintenance of the exhaust fans from twice per year to monthly.

A review of work orders and invoices from the HVAC service provider for 2013 and 2014 identifies many visits dealing with system malfunctions including: blown fuses, thermostat faulty, units down, unit not cooling, system completely out of freon, unit making a clicking noise, unit never been cleaned and unit running short of refrigerant. Documentation was available to support that inspections had been conducted by a certified individual.

At the time of inspection, it was identified by staff that a number of individually switched exhaust fans had been taken out service in April 2014 as a precautionary measure, following the incident with the exhaust fan motor in one resident home area (RHA) utility room. Actions had not been completed to restore operation of the majority of the identified fans.

The lack of inspection of the HVAC system by a certified individual at required intervals is a potential risk to the health, comfort,safety and well being of residents. Preventative maintenance of major building operational systems better assures that systems are maintained to manufacturers' specifications and remain safe and in a good state of repair.

A Compliance Order for O.Reg. 79/10, s.90(2) was issued on March 3, 2013 during inspection 2013_178102_0014 and returned to compliance on July 12, 2013. [s. 90. (2) (c)]

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. 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 Minimizing of Restraint's policy was complied with.

Under LTCHA, O. Reg. 79/10 s. 109, Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, (g)how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

Review of the home's policy "Restraining of Residents-Minimizing" (8-210)revised December 2013 indicated:
Registered Nurses Responsibilities-monthly documentation required when minimizing restraining of residents assessments using "Analysis of Use of Physical Device Restraints" audits.

During the course of the inspection, Inspector #553 identified that Resident #31 had a restraint applied that was not in accordance with the physician's order.

Review of the restraint audits for the home for 2014 indicated:
-one unit had audits completed only for 2 months during 2014.

-a second unit had audits completed only for two months during 2014.
-a third unit had only one audit completed during 2014.

Interview with DOC indicated that the expectation of the charge nurse for each unit is to complete audits on restraints weekly and in doing this, the entire home should have a restraint audit completed monthly. The DOC indicated that the home has not kept up with the requirements listed in the home's policy. [s.8(1)(a),s.8(1)(b)]

2. The licensee failed to ensure that the home's policy "Falls Prevention and Management Program" and "Falling Star Committee Pilot" was complied with.

Under O.Reg. 79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls preventions and management program to reduce the incident of falls and the risk of injury.

Review of the homes policy "Fall Prevention and Management program" (8-41) revised August 2013 indicated under procedure:
-the RN/RPN is to notify the Power of Attorney(POA) of care of the fall, indicate the level of risk according the Morse fall risk assessment in the care plan, monitor and evaluate the Care Plan in collaboration with the interdisciplinary team.
-If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary.
-the Unit Manager is to facilitate a monthly falls review for all falls in the past month, ensure care plans are updated and assign responsibility for interventions.
-the HCA is to follow the interventions as outlined in the care plan.

Review of the homes policy "Falling Star Pilot" (8-41A) (revised December 2013) indicated:
-purpose of the program was to reduce the number of resident falls by 10% over a period of one year in Woodland Home Area by focusing on preventative measures for those residents with very high, high, and moderate fall risks who have experienced more than one fall in any one month.
-structured to include an interdisciplinary representation of staff (1 RN, 1 Physio, 1 HCA, 1 RPN, 1 recreation, and 1 housekeeper)
-responsibility of all committee members included: identify residents from previous monthly data that require to be placed on the program, ensure logo in place for falling

staff program on resident doorway, and use form F8-21c to identify all potential interventions and those implemented with implementation date, to prevent and minimize risk (#111).

3. Related to log #000919-14:

The health care record for Resident #49 indicates the resident is at risk for falls. The plan of care, related to falls, includes the provision of one-to-one supervision.

Interview of the Unit Manager by Inspector #111, to clarify the one-to-one supervision for Resident #49, indicated it included 12 hours of one-to-one supervision (during a specified time)which is intended to be provided when the resident is awake. The Unit Manager indicated that breaks and call-ins for this shift are not replaced.

Review of the progress notes for Resident #49 indicated the resident had sustained 7 falls during a three month period. Five of the falls that occurred were unwitnessed falls despite being within the specified time period of one-to-one supervision.

Therefore, the intervention as set out in the plan of care was not provided to the resident on the dates and times noted above.

Post-fall assessments have been completed for each of the above noted falls. The assessments for falls that occurred on 4 of the falls, indicate that the plan of care was not reviewed. A review of the plan of care demonstrates that the most recently implemented intervention is the use of special mattress in that was in place prior to the 3 month period, and the addition of an alarming device that was also in place during the first month of the falls.

The plan of care was not reviewed and revised when the care set out in the plan was not effective, as evidence by 4 subsequent falls that occurred following the implemented interventions.(#148).

In addition, review of the progress notes for Resident #49 indicated the 2nd last fall that occurred resulted in the resident sustaining an injury and was not reported to the POA of care (as per the home's policy). The process (that was in place at the time of the fall) for communicating to the POA was unclear and resulted in no documented evidence that the POA was notified of the fall.(#111).

4. Review of the progress notes for Resident #36 indicated the resident sustained 5 falls over a five month period and did not sustain any injury.

Review of Resident #36 current care plan related to falls indicated the resident is a "moderate risk" for falls, is to be added to the falling star program, and a "falling star" logo placed on the resident's door.

Review of the Morse Fall Assessments for Resident #36(completed after two of the falls) indicated the resident is a "very high risk" for falls.

Interview with Physiotherapist and Registered nursing staff indicated that Resident#36 is a "high risk" for falls and should have a falling star logo on the resident's door. The Physiotherapist indicated the Charge Nurse is responsible for ensuring the residents identified as high risk for falls receive the falling star logo. Interview with Registered nursing staff and PSW's indicated Resident#36 is at high risk for falls.

The care plan for Resident #36 had not been revised to reflect the resident's current risk for falls and the falling star logo was not observed in place at Resident #36 door during the inspection(#552).

5. Regarding Log #000818-14:

Review of progress notes for a one year period indicated that Resident #51 sustained 17 falls in the resident's room (except for 3 falls). The last fall which occurred resulted in Resident #51 being transferred to hospital and sustaining an injury.

Review Resident #51's plan of care (prior to the last fall) related to falls identified the resident as being at "Moderate Risk" for falls. Interventions included to be part of the Falling Star Program, including the placement of a "falling star logo" on doorway to alert staff. The care plan was revised after the last fall and indicated the resident was now identified as being at "High Risk" for falls. The interventions remained unchanged.

Interview of PSW #130 indicated the "falling star logo" is indicated for residents who are at "high risk for falls", when asked whether Resident #51 would be classified as requiring this, PSW #130 indicated that no, Resident #51 did not require a "falling star logo" as the resident was not at high risk for falls. RN #104 stated that Resident #51 is to have a "falling star logo" on doorway as Resident #51 is identified as being at "high

risk" for falls.

Observation of Resident #51's indicated the resident did not have a "falling star logo" located on doorway. There was inconsistent "risk for falls" identified and despite the resident's ongoing falls, interventions were not revised when interventions utilized were not effective.(#553).

6.Review of Resident #10 progress notes (during an 8 month period) the resident sustained 4 falls which were all related to toileting. The third fall resulted in a minor tissue injury. The resident was assessed by physio on the second month and indicated the resident had difficulty with the use of a mobility aid due to impaired gait and poor vision and recommended staff to provide the resident with verbal cueing related to use of the mobility aid. That same month, a care conference was held with family and identified concern regarding increased falls. Interventions included placing the resident on a toileting routine.

Review of the care plan (in place during that 8 month period) for Resident #10 indicated the resident was a "high risk" for falls related to unsteady gait and cognitive impairment. Interventions included recommendations from physio.

There was no indication the resident's care plan was reviewed and revised to include the resident's risk for falls related to poor vision, interventions included recommendations from physio and no indication of recommendations from the care conference. There were also no other approaches considered when the resident continued to fall. There was no indication the resident was to be placed on the falling star program or a fall logo placed on the resident's door as per the home's policy.

Interview of the Falling Star Committee lead (RN#110) indicated was a charge nurse on a specified unit, meets monthly with the falling star team (which includes physio, housekeeping, and an RPN from the unit when possible), use PointClickCare (PCC) to track which residents have fallen the previous month and has " a discussion" regarding who has fallen, how many times they have fallen, why each resident has fallen and possible interventions. RN#110 indicated the discussions were not documented as resident specific, because they did not want to leave personal resident information in the falling star binder. RN#110 indicated the registered staff attending the meetings were responsible for updating each of the resident's care plan. RN #110 indicated the "star" logo is applied to the resident's doorway if they are a "high risk" for falls but confirmed that Resident #10 did not have a logo because despite the

resident falling twice in one month, it was due to illness.

The "purpose" of the "Falling Star Committee Pilot" policy(revised December 2013) indicated it was only to be used for one year and only references using one out of 4 units in the home, despite being applied to all units. The Charge Nurse (and not the Unit Manager as per the policy) facilitates the monthly meetings. Review of the meeting minutes for the Falling Star Committee indicated all residents who sustained a fall the previous month are reviewed, there was no documentation of causes/interventions to be used to prevent future falls regarding specific residents and no one individual is assigned responsibility of updating the resident's care plans related to falls. [s. 8. (1) (a),s. 8. (1) (b)]

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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures for cleaning and disinfecting of supplies and devices, including personal assistance services devices, assistive aids and contact surfaces were implemented.

Review of the homes policy "Equipment-resident owned mobility and seating devices" (14-80) indicated the Registered Nursing Staff and Environmental staff will establish a cleaning routine for equipment and ensure that Health Care Aides/night watch person clean equipment on a regular basis either by hand washing, inter-steamer or the HUBSCRUB system. Interview of the Administrator by Inspector #102 indicated that their is currently no Environmental Manager in place and no documented evidence a cleaning routine was provided.

The following observations were made regarding resident mobility aides:
-Observations by Inspector #570 over a two day period, noted Resident #34 & #37 each had an unclean mobility aid. Resident #21 had an unclean mobility aid, restraint and related device with dried food stains. Resident #1 had dried food on a part of the mobility aid.

The following observations were made regarding resident personal care equipment:
-observation by Inspector # 552 on a specified day, noted Resident #16 had an attachement to a mobility aid that was on the toilet seat that had feces on it.
-observation by Inspector #570 on a specified day, noted a used catheter bag which was placed on the grab bar next to the toilet for Resident #19 which is a shared bathroom. [s. 87. (2) (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 procedures for cleaning and disinfecting of supplies, devices and personal assistive devices/aids are implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team is involved in the coordination and implementation of the Infection Prevention and Control(IPAC) program.

Interview of the IPAC lead indicated that the IPAC committee is currently not interdisciplinary. Review of the meeting minutes (August 2014) indicated only nursing attended the meeting. [s. 229. (2) (a)]

2. The licensee has failed to ensure that the Infection Prevention and Control committee meet at least quarterly.

Interview of the IPAC lead indicated she was only aware of one meeting held (August 19, 2014). [s. 229. (2) (b)]

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The following observations were made regarding resident portable oxygen containers:
-Observation of soiled utility rooms on Creekside unit (lower level) section A&B on

September 3 &4, 2014 had both the oxygen refill tank and 4 portable oxygen containers stored on the floor directly beside and below the hopper sink. The hopper sink is used to clean heavily soiled clothing/items.
-Observation of soiled utility rooms on Hilltop unit (main level) section C had one portable oxygen container with no physical barrier from the hopper sink by Inspector #570 on September 3, 2014.
-Observation of soiled utility rooms on Pathway unit (lower level) section H had one portable oxygen canister and the refill machine in the soiled utility room stored by the hopper by Inspector #552.
-Observation of soiled utility room on Woodland (main level secure unit) section F had portable oxygen tank stored near hopper on September 4, 2014 by Inspector #553.
This poses a risk of cross contamination via air droplets.

The following observations were made over a 2 day period regarding resident personal care equipment:
-observation by Inspector # 552 noted Resident #35 & #38 had an unlabelled denture cup in use in a shared washroom. Resident #30 had 2 unlabelled urine hats stored in a shared washroom. There was an unlabelled and used soap dish in a shared washroom for Resident #10.
-observation by Inspector #553 noted unlabelled nail clippers in the shower room on Woodland unit. There was an unlabelled denture cup in a shared bathroom for Resident #28. There was an unlabelled hairbrush and nail file in the shared bathroom of Resident #8.
-observation by Inspector #570 noted a used catheter bag and a unlabelled urine hat which was placed on the grab bar next to the toilet for Resident #19 which is a shared bathroom.
-observation by Inspector #111 noted the tub room on a specified resident unit had 2 brushes and 4 combs that were used with hair in them and not labelled. There was also one nail clipper not labelled. [s. 229. (4)]

4. The licensee has failed to ensure that residents were offered immunizations against tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of health care records indicated:
- Resident #40 & #41 had no indication tetanus and diptheria were offered.

Interview of the DOC indicated that the home currently does not track immunizations

of tetanus and diptheria. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team is involved in the coordination and implementation of the Infection Prevention and Control(IPAC) program, meets at least quarterly, and that staff participate in the implementation of the IPAC program, and ensure resident are offered tetanus and diptheria immnuzations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for Resident #14 included the planned care related to the use of a mobility aid.

Resident #14 was observed on two separate dates sitting in mobility aid in a tilted position. The resident reported feeling comfortable.

Interview with RPN #108 indicated that when Resident #14 is up in the mobility aid, the resident wants to be tipped back and a pillow placed behind head. Interview with PSW #130 and #132 indicated that Resident #14 uses a tilt mobility aid for positioning and comfort. The resident likes to be reclined. Interview with Physiotherapist #133 indicated that the purpose of using the tilt mobility aid of Resident #14 is for positioning.

The current written plan of care for Resident #14 does not include the current care provided by staff regarding the use of tilt mobility aid and Resident #14's preferences to be tilted and use of pillow behind head when in the mobility aid. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care for Resident #31 set out clear direction to staff and others related to restraints.

Resident #31 was observed over 4 days to have a trunk restraint applied at all times.

Review of current plan of care for Resident #31 related to restraints indicated the use of a moblity aid with has a trunk restraint is used for better upper body support and for safety, to prevent falls. There was no indication when the trunk restraint was to be applied.

Interviews with PSW #122 indicated that Resident #31's trunk restraint is applied whenever Resident #31 is up in the mobility aid. PSW #123 indicated that the restraint is applied according to the plan of care, and the trunk restraint is applied first thing in the morning.

Review of current physician orders for Resident #31 indicated "[trunk restraint] to be applied during meals for safety". [s. 6. (1) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident-staff communication system is easily seen and accessible to Resident #14 when in wheelchair in bedroom.

Review of clinical records for Resident #14 indicates that the resident is at moderate risk of falling and the resident has a tendency to transfer self from bed and wheelchair.

Review of progress notes for Resident #14 indicates that the resident had three falls from the wheelchair on 3 specified months.

The current plan of care directs staff to reinforce need to call for assistance and ensure call bell is accessible at all times.

Interview with RPN #108 indicated that Resident #14 is able to use the call bell.

On 2 separate dates Resident #14 was observed sitting in a mobility aid in the room and on both occasions the call bell was not within reach to the resident. [s.17(1)(a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided to Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The President of the Residents' Council confirmed during an interview with Inspector #570 that the Residents' Council does not receive written responses within 10 days from the Administrator when there is a concern or recommendation brought forward by the Residents' Council.

Review of the Residents' Council minutes for a specified month indicated that the council raised concerns related to Nursing, Laundry and Food and Nutrition services. The Residents' Council received a written response from the Acting Director of Resident Care regarding Nursing concerns 13 days later. The Residents' Council received a written response from The Manager of Nutritional Services regarding Food and Nutrition concerns 18 days later. There is no documented evidence that a written response to Laundry concerns raised was provided to the Residents' Council.

Review of the Residents' Council minutes of another specified month indicated that the Council raised concerns related to Nursing and Environmental services. The administrator discussed the environmental concerns with the Council at the meeting. There is no documented evidence that a written response to Environmental and Nursing concerns raised by the Residents' Council was provided to the Residents' Council.

Interview of the Administrator indicated that concerns raised by the council are dealt with on the spot at the meeting. The Administrator confirmed to inspector #570 that a written response was not given within 10 days to the Residents' Council when concerns or recommendations are brought forward by Residents' Council. [s. 57. (2)]

WN #8: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Regarding Log # 000818-14:

The licensee failed to informed the Director no later than one business day after the occurrence of an incident involving Resident #51 where the resident was taken to hospital after sustaining a fall that resulted in an injury.

Review of Critical Incident Report (CIR) submitted to the Director on an identified date, for an incident that occurred four days earlier. The CIR indicated Resident #51 was found on the floor in bathroom and based on the assessment, Resident #51 was transferred to hospital and sustained an injury and returned to the home four days later.

Interview with RN #131 indicated the Director was notified when the CIR was submitting and indicated they failed to meet the requirements of the legislation to report the incident to the Director as required. [s. 107. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied Resident #31's physical device in accordance with instructions specified by the physician.

Resident #31 was observed on 4 specified dates to have a trunk restraint applied outside of mealtimes.

Review of current physician's orders for Resident #31 indicated a "{trunk restraint} to be applied during meals for safety".

Interviews with PSW #122 indicated that the trunk restraint is applied for Resident #31 all the time while the Resident is awake. PSW #123 stated that Resident #31's "[trunk restraint] is applied first thing in the morning, and it may be left on all day as needed". [s. 110. (2) 2.]

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 that are stored in the medication cart were secure and locked.

On a specified date (during the lunch service) on a specified unit, it was observed by Inspector #553 that Staff #125 left the medication cart unattended and unlocked for a 2 minute period of time and the top of the medication cart had medications accessible. Staff #125 then returned to the medication cart. The registered staff member then left the medication cart again to administer medication to a resident, again leaving the medication cart unattended and unlocked. The bottom drawer of the medication cart (containing medications) was not completely shut (and subsequently opened in the absence of the registered staff member.

Interview of Staff #125 when returning to the medication cart indicated the expectation is to ensure the cart is locked when unattended and to be cleared off of any medication.[s.129(1)(a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2014_199161_0008	148
O.Reg 79/10 s. 53. (4)	CO #901	2013_196157_0015	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #902	2013_196157_0015	111

Issued on this 3rd day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), AMANDA NIXON (148), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553), SAMI JAROUR (570), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_360111_0022
Log No. / Registre no:	O-000843-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 19, 2014
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul O'Krafka

To MARYCREST HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure that procedures are developed and implemented to ensure that HVAC systems are inspected at least every six months by a certified individual.

Grounds / Motifs :

1. 1. Related to log#000358-14:

The licensee has failed to ensure that procedures are developed and implemented to ensure that HVAC systems are inspected at least every six months by a certified individual.

A critical incident report(CI) was received on a specified date for a fire in an exhaust fan that occurred on a specified unit. The CI indicated procedures would be developed and implemented to increase the frequency of inspections as part of the preventative maintenance of the exhaust fans from twice per year to monthly.

A review of work orders and invoices from the HVAC service provider for 2013 and 2014 identifies many visits dealing with system malfunctions including: blown fuses, thermostat faulty, units down, unit not cooling, system completely out of freon, unit making a clicking noise, unit never been cleaned and unit running short of refrigerant. Documentation was available to support that inspections had been conducted by a certified individual.

At the time of inspection, it was identified by staff that a number of individually switched exhaust fans had been taken out service in April 2014 as a precautionary measure, following the incident with the exhaust fan motor in one resident home area (RHA) utility room. Actions had not been completed to restore operation of the majority of the identified fans.

The lack of inspection of the HVAC system by a certified individual at required intervals is a potential risk to the health, comfort,safety and well being of residents. Preventative maintenance of major building operational systems better assures that systems are maintained to manufacturers' specifications and remain safe and in a good state of repair.

A Compliance Order for O.Reg. 79/10, s.90(2) was issued on March 3, 2013 during inspection 2013_178102_0014 and returned to compliance on July 12, 2013. [s. 90. (2) (c)] (102)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is to prepare, submit and implement a corrective action plan to demonstrate the following actions are taken, and the person responsible for each action, and by the required date of compliance.

1) The licensee is to review and revise the plan of care immediately for Resident #10, #36, #49, and #51 related to falls as per the homes policy on "Falls Prevention Management" to ensure:
-the plan of care is based on the each resident's current assessed needs,
-the care is provided to the resident as indicated in the plan,
-is revised when the care needs change or the interventions utilized have been ineffective,
-and different approaches are considered to reduce the incidence of falls or reduce the risk of injury.

2)The licensee shall retrain all staff on the home's policy of "Falls Prevention and Management" and "Falling Star Committee Pilot" to with a focus on ensuring:
- the POA (as per the policy) is notified when a resident has fallen,
-all staff have a clear understanding of the levels of risk for falls as outlined in the policy,
-how residents care as per the Falls Prevention Program is directed at risk for falls and related interventions are linked to the Falls Prevention Program,
-that all direct care understand and demonstrate how these resident's at risks for falls and related interventions are consistent with the Falls Prevention and Management Program to ensure both policies are complied with.
-and, a monitoring process is established for ensuring compliance.

The plan is to be submitted to Lynda Brown via email at Lynda.Brown2@ontario.ca or via fax at 1-905-433-3013 by September 29, 2014.

Grounds / Motifs :

1. 2. The licensee failed to ensure that the home's policy "Falls Prevention and Management Program" and "Falling Star Committee Pilot" was complied with.

Under O.Reg. 79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls preventions and management program to reduce the incident of falls and the risk of injury.

Review of the homes policy "Fall Prevention and Management program" (8-41) revised August 2013 indicated under procedure:
-the RN/RPN is to notify the Power of Attorney(POA) of care of the fall, indicate the level of risk according the Morse fall risk assessment in the care plan, monitor and evaluate the Care Plan in collaboration with the interdisciplinary team.
-If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary.
-the Unit Manager is to facilitate a monthly falls review for all falls in the past month, ensure care plans are updated and assign responsibility for interventions.
-the HCA is to follow the interventions as outlined in the care plan.

Review of the homes policy "Falling Star Pilot" (8-41A) (revised December 2013) indicated:
-purpose of the program was to reduce the number of resident falls by 10% over a period of one year in Woodland Home Area by focusing on preventative measures for those residents with very high, high, and moderate fall risks who have experienced more than one fall in any one month.
-structured to include an interdisciplinary representation of staff (1 RN, 1 Physio, 1 HCA, 1 RPN, 1 recreation, and 1 housekeeper)
-responsibility of all committee members included: identify residents from previous monthly data that require to be placed on the program, ensure logo in place for falling staff program on resident doorway, and use form F8-21c to identify all potential interventions and those implemented with implementation date, to prevent and minimize risk (#111).

3. Related to log #000919-14:

The health care record for Resident #49 indicates the resident is at risk for falls. The plan of care, related to falls, includes the provision of one-to-one supervision.

Interview of the Unit Manager by Inspector #111, to clarify the one-to-one supervision for Resident #49, indicated it included 12 hours of one-to-one supervision (during a specified time)which is intended to be provided when the resident is awake. The Unit Manager indicated that breaks and call-ins for this shift are not replaced.

Review of the progress notes for Resident #49 indicated the resident had sustained 7 falls during a three month period. Five of the falls that occurred were unwitnessed falls despite being within the specified time period of one-to-one supervision.

Therefore, the intervention as set out in the plan of care was not provided to the resident on the dates and times noted above.

Post-fall assessments have been completed for each of the above noted falls. The assessments for falls that occurred on 4 of the falls, indicate that the plan of care was not reviewed. A review of the plan of care demonstrates that the most recently implemented intervention is the use of special mattress that was in place prior to the 3 month period, and the addition of an alarming device that was in place during the first month of the falls.

The plan of care was not reviewed and revised when the care set out in the plan was not effective, as evidence by 4 subsequent falls that occurred following the implemented interventions.(#148).

In addition, review of the progress notes for Resident #49 indicated the 2nd last fall that occurred resulted in the resident sustaining an injury and was not reported to the POA of care (as per the home's policy). The process (that was in place at the time of the fall) for communicating to the POA was unclear and resulted in no documented evidence that the POA was ever notified of the fall. (#111).

4. Review of the progress notes for Resident #36 indicated the resident sustained 5 falls over a five month period and did not sustain any injury.

Review of Resident #36 current care plan related to falls indicated the resident is a "moderate risk" for falls, is to be added to the falling star program, and a "falling star" logo placed on the resident's door.

Review of the Morse Fall Assessments for Resident #36(completed after two of the falls) indicated the resident is a "very high risk" for falls.

Interview with Physiotherapist and Registered nursing staff indicated that Resident#36 is a "high risk" for falls and should have a falling star logo on the resident's door. The Physiotherapist indicated the Charge Nurse is responsible

for ensuring the residents identified as high risk for falls receive the falling star logo. Interview with Registered nursing staff and PSW's indicated Resident#36 is at high risk for falls.

The care plan for Resident #36 had not been revised to reflect the resident's current risk for falls and the falling star logo was not observed in place at Resident #36 door during the inspection(#552).

5. Regarding Log #000818-14:

Review of progress notes for a one year period indicated that Resident #51 sustained 17 falls in the resident's room (except for 3 falls). The last fall which occurred resulted in Resident #51 being transferred to hospital and sustaining an injury.

Review Resident #51's plan of care (prior to the last fall) related to falls identified the resident as being at "Moderate Risk" for falls. Interventions included to be part of the Falling Star Program, including the placement of a "falling star logo" on doorway to alert staff. The care plan was revised after the last fall and indicated the resident was now identified as being at "High Risk" for falls. The interventions remained unchanged.

Interview of PSW #130 indicated the "falling star logo" is indicated for residents who are at "high risk for falls", when asked whether Resident #51 would be classified as requiring this, PSW #130 indicated that no, Resident #51 did not require a "falling star logo" as the resident was not at high risk for falls. RN #104 stated that Resident #51 is to have a "falling star logo" on doorway as Resident #51 is identified as being at "high risk" for falls.

Observation of Resident #51's indicated the resident did not have a "falling star logo" located on doorway. There was inconsistent "risk for falls" identified and despite the resident's ongoing falls, interventions were not revised when interventions utilized were not effective.(#553).

6.Review of Resident #10 progress notes (during an 8 month period) the resident sustained 4 falls which were all related to toileting. The third fall resulted in a minor tissue injury. The resident was assessed by physio on the second month and indicated the resident had difficulty with the use of a mobility aid due to impaired gait and poor vision and recommended staff to provide the resident

with verbal cueing related to use of the mobility aid. That same month, a care conference was held with family and identified concern regarding increased falls. Interventions included placing the resident on a toileting routine.

Review of the care plan (in place during that 8 month period) for Resident #10 indicated the resident was a "high risk" for falls related to unsteady gait and cognitive impairment. Interventions included recommendations from physio.

There was no indication the resident's care plan was reviewed and revised to include the resident's risk for falls related to poor vision, interventions included recommendations from physio and no indication of recommendations from the care conference. There were also no other approaches considered when the resident continued to fall. There was no indication the resident was to be placed on the falling star program or a fall logo placed on the resident's door as per the home's policy.

Interview of the Falling Star Committee lead (RN#110) indicated was a charge nurse on a specified unit, meets monthly with the falling star team (which includes physio, housekeeping, and an RPN from the unit when possible), use PointClickCare (PCC) to track which residents have fallen the previous month and has " a discussion" regarding who has fallen, how many times they have fallen, why each resident has fallen and possible interventions. RN#110 indicated the discussions were not documented as resident specific, because they did not want to leave personal resident information in the falling star binder. RN#110 indicated the registered staff attending the meetings were responsible for updating each of the resident's care plan. RN #110 indicated the "star" logo is applied to the resident's doorway if they are a "high risk" for falls but confirmed that Resident #10 did not have a logo because despite the resident falling twice in one month, it was due to illness.

The "purpose" of the "Falling Star Committee Pilot" policy(revised December 2013) indicated it was only to be used for one year and only references using one out of 4 units in the home, despite being applied to all units. The Charge Nurse (and not the Unit Manager as per the policy) facilitates the monthly meetings. Review of the meeting minutes for the Falling Star Committee indicated all residents who sustained a fall the previous month are reviewed, there was no documentation of causes/interventions to be used to prevent future falls regarding specific residents and no one individual is assigned responsibility of updating the resident's care plans related to falls. [s. 8. (1) (a),s. 8. (1) (b)]

(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 19th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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