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 prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018;	2018_724640_0009 (A1)	005221-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Tall Pines Long Term Care Centre
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

Amended by HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changes were made to CO #003 to amend the required actions, specifically item (c). The Compliance Due Date (CDD) was changed to July 20, 2018.

Issued on this 14 day of August 2018 (A1)

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

Original report signed by the inspector.

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Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 22, 23, 26, 27, 28, 29 and April 3, 4, 5 and 6, 2018.

During the course of the inspection, the following critical incident inspections were conducted;

Intake #001865-18 related to a fall with injury and,

Intake #002450-18 related to a fall with injury.

The following Complaint inspection was conducted;

Intake #003949-18 regarding care of a resident.

An inquiry was completed for Intake #028524-17 related to care concern of a resident.

During the course of the inspection, the Inspectors toured the home, observed the provision of care and services, interviewed residents, families and staff, reviewed relevant documents including but not limited to: clinical records, policies and procedures, maintenance logs and meeting minutes.

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council representative, Family Council representative, housekeeping aides, facility services staff, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Dietary aides, Supervisor Dietary, Supervisor Facility, Supervisors of Care (SOC), Resident Assessment Instrument (RAI) Specialist, Coordinator Social Work, Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Resident Charges

Residents' Council

Skin and Wound Care

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

14 WN(s)
7 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection prevention and control program.

1) On a specified date in March, 2018, Long-term Care Homes (LTCH) Inspectors #586 and #695 observed a contact precautions sign posted outside of a resident room. The contact precautions sign stated that gloves and gowns must be used while providing resident care.

Gowns and masks were found in the personal protective equipment (PPE) cart outside the room however, gloves were not found in the cart or inside the resident's room.

LTCH Inspector #695 reviewed the clinical record and found the written plan of care directed staff are to use contact precautions for the provision of direct care.

The home's policy "Infection Prevention and Control Program", policy # LTC8-08.04 with a revised July 30, 2014, stated that residents identified as positive for ESBL Class A should be placed on contact precautions "for the provision of direct care." In the home's "Infection Prevention and Control Program", policy #LTC8-03.08 with a revised date of November 8, 2017, it directed that when residents were on contact precautions, "gloves and gowns must be used for direct contact with the resident or their environment, including objects and equipment in this environment."

On a specified date in March 2018 resident #013 verbalized they required care to LTCH Inspector #640 who informed Personal Support Worker (PSW) #102. PSW #102 was observed taking a mechanical lift and going to the residents room. PSW #102 entered resident #013's room without donning a gown or gloves.

RPN #104 was asked by the LTCH Inspectors what the expectation of PPE use related to the provision of care for this resident. RPN #104 informed the LTCH

Inspectors that all staff who provided direct care must wear both gown and gloves.

During an interview with RPN #104 with the LTCH Inspector, they acknowledged that the two PSWs failed to don PPE as required to prevent the transfer of infection.

2) On a specific date in April 2018, the LTCH Inspector observed the following related to resident #015 on contact precautions;

a) PSW #109 was observed in a resident room on isolation precautions, leaning against the resident bed and removing items from the breakfast tray and taking the resident's tray away. The PSW was not wearing gloves or gown. When they left the room, the Long-Term Care Homes (LTCH) Inspector did not observe the staff perform hand hygiene.

The home's policy "Routine Practices - Hand Hygiene", policy #LTC98-03.01 with a revised date of May 9, 2016, directed staff to perform hand hygiene before and after providing resident care.

The home's policy "Routine Practices - Additional Precautions", policy #LTC8-03.08, with a revised date of November 8, 2017, directed staff in addition to routine practices, contact precautions included the donning of gloves and gowns for direct contact with the resident or their environment including objects and equipment in their environment.

The same PSW re-entered the room with another food item for the resident. The PSW did not perform hand hygiene nor don gown and gloves prior to entering the room. They were touching the bed and the resident's over bed table. The PSW left the resident room and did not perform hand hygiene.

b) PSW # 137 was observed entering a resident room on isolation precautions, leaning against the resident bed and removing items from the over bed table and had put their hand on the resident's bed rail. The PSW was not wearing gloves or gown. When they left the room, the Long-Term Care Homes (LTCH) Inspector did not observe the staff perform hand hygiene.

The home's policy "Routine Practices - Hand Hygiene", policy #LTC98-03.01 with a revised date of May 9, 2016, directed staff to perform hand hygiene before and after providing resident care.

The home's policy "Routine Practices - Additional Precautions", policy #LTC8-03.08, with a revised date of November 8, 2017, directed staff in addition to routine practices, contact precautions included the donning of gloves and gowns for direct contact with the resident or their environment including objects and equipment in their environment.

The same PSW re-entered the room with another item for the resident. The PSW did not perform hand hygiene nor don gown and gloves prior to entering the room. They were touching the bed and the resident's over bed table and repositioned the resident's left arm. The PSW left the resident room and did not perform hand hygiene.

During an interview with the Director of Care (DOC), they stated it was an expectation of the home that all staff follow the requirements of wearing gowns and gloves when direct contact with the resident or their equipment was expected. The DOC acknowledged the PSWs had not followed the expected practice. [s. 229. (4)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a specified date in March 2018, resident #003 was observed to have altered skin integrity.

The home's policy "Skin and Wound Care Program" with a revised date of June 27, 2016, directed Personal Support Workers (PSW) to observe the resident's skin daily and report any reddened areas or other areas of concern to the registered staff. The registered staff were directed that when a new area of altered skin integrity, which also included eczema, rash and abnormal skin lesion, to complete a Skin and Wound assessment in the assessment tab of PointClickCare (PCC), the home's electronic documentation system.

The LTCH Inspector reviewed the resident's clinical record which revealed the resident had not been assessed for the altered skin integrity.

During an interview with PSW #114, they told the LTCH Inspector that during bath days, the PSW trimmed resident #003's fingernails. PSW staff were to notify the registered staff if skin issues were observed. PSW #114 could not remember how long the resident had the altered skin integrity.

The LTCH Inspector interviewed RPN #108 who was unable to find any skin assessment related to the altered skin integrity in the clinical record. They told the LTCH Inspector the skin assessment was to be completed upon admission and with any skin concerns.

During an interview with Supervisor of Care #115, the Skin and Wound Care Lead for the home, they informed the LTCH Inspector that it was an expectation of the home that PSW staff inform the registered staff when any areas of altered skin integrity were observed. It was expected that the registered staff complete a Skin and Wound assessment and notify the physician. Registered staff were expected to revise the plan of care to include the altered skin integrity and implement interventions appropriate for the skin concern.

SOC #115 acknowledged that staff had not completed a Skin and Wound assessment related to the altered skin integrity for resident #003. [s. 50. (2) (b) (i)]

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. 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,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

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

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

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

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained.

During stage one of the Resident Quality Inspection (RQI), the home triggered for accommodations services, common areas in disrepair during observations of residents' rooms.

The inspector observed the following residents' bathrooms:

-one of the light bulbs on the ceiling and a light fixture above the bathroom counter was burnt out.
- the light on the wall above the bathroom counter was burnt out and the light fixture cover was noted on the bathroom counter.
-a light bulb on the light fixture on the bathroom ceiling was burnt out.

Interviews with PSWs #106, Housekeeper #105, RPN #107, and Maintenance Personel #112 indicated that they were not aware that lights in the above mentioned residents rooms were burnt out and did not know how long the lights bulbs had been burnt out. They indicated that it was all their responsibilities to report to the maintenance department when they noticed the lights were not working and they indicated the maintenance department was not aware.

Interview with the Supervisor Facility indicated the home had a schedule on a monthly rotational basis to ensure that all rooms are checked for deficiencies such as burnt out light bulbs but indicated the last time the above mentioned rooms were checked was in September 2017, and has not been checked since then. [s. 90. (2) (d)]

2. The licensee failed to ensure that water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

As a result of several complaints from residents and a family member regarding the temperature of the water, the Long-Term Care Homes (LTCH) Inspector did random monitoring of water temperatures throughout the building.

In a common resident bathroom, the LTCH Inspector captured the water temperature from the hot water tap at the hand basin at 58.8 degrees Celsius (C). In a second common resident bathroom, from the hand basin hot water tap, the temperature was captured at 55.5 degrees C.

The home's policy "Water Supply, Water Temperature and Back-Flow Prevention Device", policy #LTC6-06.18 with a revised date of March 27, 2018, stated that

water temperatures for the purpose of cleaning or showering shall not exceed 49 degrees Celsius and not below 40 degrees Celsius. If the temperature exceeds 49 degrees Celsius then Facility Services staff were to be notified immediately, so that the source could be shut down for repairs.

The common resident bathrooms were not included in part of the random monitoring of water temperatures within the home.

The Supervisor Facility was interviewed and they were unaware of why these water temperatures were too high. They acknowledged the water temperatures were above the expected high range of 49 degrees Celsius and would take action to resolve the issue. [s. 90. (2) (g)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius (C).

During an inspection regarding complaints of water temperatures, the Long-Term Care Homes (LTCH) Inspector monitored water temperatures in random locations where residents had access to hot water.

In two hand basins in the common resident washrooms, one on first floor and one on third floor, the water temperatures were found to be 55.5 degrees C and 58.8 degrees C respectively.

The LTCH Inspector informed RPN #130 and RN #138 who immediately called the maintenance department and reported the issue.

During an interview with the Supervisor Facility (SF), Maintenance hand #112 informed the LTCH Inspector they had received the call, had checked the home areas and found the water temperatures to be 44 and 45 degrees C but took no immediate action. When asked to confirm the location of the temperatures that were taken, the staff member stated they had taken the water temperatures in two rooms that were not the two rooms as reported.

The LTCH Inspector asked the SF what action would be taken in regards to the two water temperatures that exceeded 49 degrees C at the hand basin in the common resident washrooms. The SF stated the two washrooms would be taken out of service.

Two hours after the initial report, LTCH Inspector #695 observed the resident bathrooms as noted above. Both washrooms remained accessible with no restrictions and no signage to state otherwise.

During an interview with the FS, they stated they did not have any documentation confirming when action was taken but believed the hot water was shut off sometime between 1330 and 1400 hours the day of notification.

The FS acknowledged the high water temperatures put residents, families and staff at risk. The FS confirmed the action taken was not immediate to address the water temperatures over 49 degrees C. [s. 90. (2) (h)]

4. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

During an inspection regarding complaints of water temperatures, the Long-Term Care Homes (LTCH) Inspector monitored water temperatures in random locations where residents had access to hot water.

In the spa room 2101, the LTCH Inspector found the water temperature at the hand basin to be 32.7 degrees C. Spa room 3101 was 35.2 degrees C and during the process, the hot water shut off.

The home's policy "Water Supply, Water Temperature and Back-Flow Prevention Device", policy #LTC6-06.18 stated "There shall be a sufficient supply of hot water to meet the needs of the residents, staff and the operation of the centre." The policy directed that water temperature for the purpose of cleaning or showering shall not exceed 49 degrees C and not below 40 degrees C.

Resident #015 informed the LTCH Inspector they had often received a bath/shower that was not a comfortable temperature and this had occurred many times over the past year. They stated an incident where they were unable to be rinsed as the water was not warm and at one time, the hot water wasn't flowing from the tap.

Resident #030 told the LTCH Inspector they had received their bath the day prior and the hot water had shut off and the resident was not able to complete the bath.

During resident #021's bath/shower, the hot water shut off for approximately three minutes according to PSW #109.

During an interview with the Supervisor Facility (FS), they informed the LTCH Inspector the home did not monitor water temperatures in any spa area, only random resident rooms on the third floor. The FS stated the home did not have any policy or procedure that directed staff to monitor the water temperatures in the bath or shower spas.

The FS acknowledged the water temperatures of the bath and showers were not monitored and therefore the home was not aware of the actual water temperature supplying the areas and available to the tubs and showers. [s. 90. (2) (i)]

5. The licensee failed to ensure the water temperature was monitored once per shift in random locations where residents had access to hot water.

During an interview with the Resident's Council, they informed the Long-Term Care Homes (LTCH) Inspector that they and others had experienced no hot water during their bath/shower times over the past several months. They had reported this at their Council meetings.

The home's policy "Water Supply, Water Temperature and Back-Flow Prevention Device", policy #LTC6-06.18 with a revised date of March 27, 2018, directed the In-Charge Nurse/designate to check water temperatures using a digital thermometer at random locations from a water source. If the temperature exceeded 49 degrees Celsius (C), staff were to immediately notify Facility Services staff. The attached "Hot Water Temperature Audit" form directed staff to document a water temperature at a resident faucet on each shift and notify maintenance staff if the temperature was less than 41 degrees C or more than 49 degrees C.

The LTCH Inspector requested the home's record of water temperatures from the Supervisor Facility. The Supervisor Facility gave the LTCH Inspector a file folder containing records of water temperatures for the third floor home areas for the months of January, February and March 2018.

The following was noted by the LTCH Inspector:

- On 18 occasions during the three months on one home area, the water

temperatures were not documented.
- On three occasions on one home area, the water temperatures in three resident rooms was documented in excess of 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.
- On three occasions on one home area, the water temperatures in three resident rooms was below 40 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.
- On 24 occasions on one home area, the temperatures were not documented.
- On three occasions staff documented there was no hot water to test. There were no corresponding maintenance work orders to verify that staff reported this to Facility Services staff.
- On six occasions on one home area, water temperatures were documented in excess of 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported this to Facility Services staff.
- On seven occasions on one home area, water temperatures were documented below 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.

The LTCH Inspector reviewed the documentation as given by the Supervisor Facility (FS) and there were water temperatures taken from resident rooms on only two of six resident home areas.

The SF went on to explain that the home only monitored water temperatures on the third floor as the water all went up the system to that area, therefore there was no reason to check the water temperatures on each floor.

During an interview with RPN # 107, they informed the LTCH Inspector they had two digital thermometers for water temperature monitoring and both were not functioning. They document a resident room basin on their shift and document it on the audit form.

During an interview with the SF and Supervisor of Care (SOC) #144 regarding the Hot Water Temperature Audit forms, they both acknowledged that staff were not following policy regarding the taking and documentation of the water temperatures, the documentation of action taken and were not always reporting water temperatures when out of range. The SOC and the SF informed the LTCH Inspector that there was no process in place for any review, auditing or follow up related to the Hot Water Temperature Audit forms.

During an interview with Maintenance personnel #139, they informed the LTCH Inspector they calibrated the digital thermometer for monitoring water temperatures by removing and replacing the battery and had done so that morning. The LTCH Inspector took the temperature of a cup of warm water using the newly calibrated LTCH Inspectors digital thermometer and the home's digital thermometer. The home's digital thermometer was 8.88 degrees Celsius lower than the LTCH Inspector's digital thermometer which had been calibrated using the ice water method and zeroed out earlier in the day.

The SF acknowledged the home did not routinely calibrate their equipment nor randomly monitor water temperatures once per shift where residents had access to hot water. [s. 90. (2) (k)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

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

Specifically failed to comply with the following:

s. 6. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that there was a written plan of care for reach resident that set out the planned care for the resident.

On a specified date in April 2018, resident #024's bed was observed with a safety device.

In an interview with Supervisor of Care (SOC) #115 and Acting SOC #129, they confirmed that the resident used the safety device for bed mobility and positioning.

A review of the resident's documented plan of care, which front line staff use to

direct care, did not include the use of the device. SOC #115 confirmed that the device was not included in the resident's documented plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #005's most recent Minimum Data Set (MDS) indicated that they required extensive assistance for toileting. The resident's documented plan of care, which front line staff use to direct care, indicated that the resident was independent with all aspects of toileting.

In interviews with PSW's #140, #142 and #143, they indicated that the resident was mostly independent with toileting during the day, but at times would need some assistance.

In an interview with the Acting SOC #129, they confirmed that the resident's MDS assessment and their plan of care were not consistent with or complemented each other, and acknowledged that the resident's plan of care was not reflective of their toileting needs.

B) The resident's Continence Care Product Evaluation Form indicated that the resident used pull ups during the day and evening and a brief overnight.

In interviews with Acting SOC #129, as well as PSW's #140, #142 and #143, and RPN #141, they indicated that the resident used an identified continent products during the day and evening and a different product during the night.

Review of the resident's documented plan of care did not include the type of continent product used; however, the unit's continent product list listed the resident as using a different identified product during the day and evening shifts, rather than the product they used.

The continence product list was not consistent with the resident's continence assessment. [s. 6. (4) (a)]

3. The licensee has failed to ensure that that the plan of care was revised when the residents care needs changed.

This Critical Incident was inspected in relation to resident #017's fall on a specified date in January 2018.

After the incident, resident #017 was sent to hospital and diagnosed with a significant acute condition as a result of the fall.

The home's policy "Falls Prevention and Management Program", with a revised date of October 24, 2016, directed registered staff to document interventions or strategies that reduced the risk of falls in the residents plan of care. After a fall, the program directed registered staff to evaluate the plan of care and if appropriate, update the strategies to reduce or mitigate further falls or falls with injury. The physiotherapist (PT) was expected to revise the plan of care, including new interventions and assistive aid devices, based on any physiotherapy assessments conducted. The program also directed personal support worker's (PSW)'s to regularly review the plan of care and provide care as documented.

The written plan of cares that were updated in January 2018, and November 2017, included several falls prevention strategies.

The post-fall physiotherapy progress notes on three occasions , stated that resident #017 was to use an identified device when needed for mobility. The post-fall physiotherapy note also requested staff to ensure the device was used to avoid a potential fall. The post-fall progress notes by different registered practical nurses (RPNs), indicated that resident #017 needed reminders and encouragement to use the device for mobility.

The written plan of cares updated on January 2018, and November 2017 did not indicate whether resident #017 used an identified device for mobility. The falls risk section of both written plan of cares failed to include the physiotherapist's recommendations. Both written plan of cares also failed to include the RPN's recommendation.

Supervisor of Care #115 confirmed that the written plan of care should have included the PT's recommendations and the mode of locomotion was expected to be in the written plan of care. They acknowledged that the interventions and mode of locomotion were not included in resident #017's written plan of care.

4. The licensee has failed to ensure that the plan of care was revised when the residents care needs changed.

A Critical Incident was received related to resident #019's fall. Resident #019 was sent to hospital. When resident #019 returned from hospital, the residents' functional status significantly changed. The Minimal Date Set (MDS) assessment indicated that the resident required extensive moderate assistance of one person for mobility.

The home's policy "Falls Prevention and Management Program", with a revised date of October 24, 2016, directed the physiotherapist (PT) to revise the plan of care, including with new interventions, based on any physiotherapy assessments conducted. In addition, the "Falls Prevention and Management Program" directed registered staff to evaluate the plan of care after a fall and if appropriate, update the strategies to reduce or mitigate further falls or falls with injury.

The written plan of care completed after the incident had multiple falls prevention and management strategies.

The post-fall physiotherapy assessment note recommended that resident #019 have specific interventions implemented to prevent a serious injury in the event of a fall.

The PT confirmed that the written plan of care was not updated for resident #019 after the PTs recommendations were made.

In an interview with SOC #115, it was confirmed that the written plan of care should have included the PTs' recommendations. Supervisor of Care #115 acknowledged that the falls management strategies recommended by the PT were not included in resident #017's written plan of care.

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 the licensee must ensure that that the plan of care is revised when the residents care needs changed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

In accordance with Regulation, Skin and wound care s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:

1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

Review of the Home's policy entitled, "Skin and Wound Program-Region of Peel Long Term Care Centres", revised June 27, 2016, indicates strategies to prevent altered skin integrity and one of the strategy directs staff use proper transferring and positioning techniques when providing care to a resident.

Review of a critical incident that reported allegations of improper care to resident #020 causing altered skin integrity due to specific equipment.

Interview with resident #020 indicated that they were left with a specific piece of equipment in place. Resident #020 indicated PSW #134 told them that they were going to get another staff member to assist and will be back. The resident indicated that the PSW did not come back for a long time and that the equipment was very uncomfortable. Further interview with resident #020 indicated that they sustained altered skin integrity.

Interview with PSW #134 indicated that resident #020 required two staff to transfer and that they had left resident #020 with the piece of equipment in place. Further interview with PSW #134 confirmed they should have gotten another staff member first before placing the piece of equipment.

The SOC indicated that that PSW #134 should never leave a resident unattended.

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 The licensee must ensure that 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, is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The home's policy, "Bed Entrapment Prevention Program" (last revised June 19, 2017) included the requirement for staff to assess a resident using the Bed Rail Risk Assessment form:
-Within 24 hours of admission
-With a significant change in health status, as clinically appropriate
-Following any incident related to safety in bed
-Following a change in bed or components of the bed system.

A) On a specified date in April 2018, resident #011's bed was observed with safety equipment engaged and two other identified equipment that extended down the bed with a significant gap left at the end of the bed.

In an interview with SOC #115 and Acting SOC #129 they indicated that the identified equipment were put into place to reduce the resident's risk of falling. They acknowledged that the resident did not have another specific assessment completed since 2015. They acknowledged that another assessment should have been completed after the equipment was added to the bed as it was considered a change in the components of the bed system, and because the resident's condition had changed since the last assessment in 2015.

B) On a specified date in April 2018, resident #023's bed was observed with safety equipment engaged and two other identified equipment that extended down the bed with a significant gap left at the end of the bed.

The date that the equipment was put into place could not be located in the resident's health record, as confirmed by SOC #115.

In an interview with SOC #115 and Acting SOC #129 they indicated that the equipment was put into place to reduce the resident's risk of falling. They acknowledged that the resident did not have another assessment completed since 2014. They acknowledged that another assessment should have been completed after the equipment was added to the bed as it was considered a change in the components of the bed system, and because the resident's condition had changed since the last assessment. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On a specified date in April 2018 resident #024's bed was observed with safety equipment engaged.

Upon admission to the home, a specific assessment was completed. The resident's bed system was not re-tested after admission and the addition of the equipment.

In an interview with Supervisor Of Care (SOC) #115 and Acting SOC #129 they

indicated that according to the home's program, an addition of the equipment was considered change in the components of the bed system and thus a Bed System Safety Measurement Test would be required. They acknowledged that this was not completed for resident #024. [s. 15. (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 The licensee must ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, 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.

During stage one of the RQI, resident #009 was indicated they had significant altered skin integrity.

Review of resident's #009's plan of care indicated the resident had significant altered skin integrity on an identified area and one of the interventions to manage this was to turn and reposition the resident when the resident was in bed.

Interview with resident #009 indicated that staff will turn and reposition them on their side when they are in bed and indicated that there were times when they did not wish to be turned and repositioned and would refuse the intervention.

Interview with PSW #123 indicated that resident #009 stated that when the resident was in bed, they were turned and repositioned onto their side.

Review of resident #009's Care Records for the months of October 2017 to March 2018 did not indicate any documentation that resident #009 was being turned and repositioned.

Interviews with RN #122 and Skin Care Coordinator Co-Chair #124 indicated that resident #009 was being turned and repositioned when they were in bed but staff did not document the intervention because a turning and repositioning schedule was not initiated. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance The licensee must 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was only restrained by a physical device, as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

A) On an identified date in April 2018, resident #011's bed was observed with specific equipment engaged at the top of the bed and two other pieces of equipment at the end of the bed.

The resident's documented plan of care included the use of the equipment to aid in bed mobility and falls prevention.

In an interview with Supervisor Of Care (SOC) #115 and Acting SOC #129 they acknowledged the equipment was limiting or inhibiting the resident's freedom of movement. SOC #129 confirmed that if the equipment was not in place, the resident would be able to get out of bed.

B) On an identified date in April, 2018, resident #023's bed was observed with specific equipment engaged at the top of the bed and two other pieces of equipment at the end of the bed.

The resident's documented plan of care included the use the equipment to aid in bed mobility.

In an interview with SOC #115 and Acting SOC #129 they acknowledged that the equipment was limiting or inhibiting the resident's freedom of movement as they were preventing the resident from getting out of bed, thus acting as a restraint.

The SOC's confirmed that the use of bilateral bolsters as a restraint was not included in the resident's plan of care. [s. 31. (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 The licensee must ensure that a resident is only restrained by a physical device, as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:

"The following charges are prohibited for the purposes of paragraph 4 of

subsection 91(1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. The Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCHA) Policy, LTCHA Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:

"The licensee must provide the following goods, equipment, supplies and services to Long-term Care Homes (LTCH) residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.

2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies

Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

If a resident was assessed to require a pull up style incontinent product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under the service accountability agreement.

A) During Stage I of the RQI, resident #005's Substitute Decision Maker (SDM) voiced concern to the Long-Term Care Homes (LTCH) Inspector that they had requested an identified continence product for the resident and were told by a PSW that the residents only get one per resident per day.

RPN #141 and Acting Supervisor Of Care (SOC) #129 indicated that the resident would obtain clean products supplied by their family. When asked why the home could not use their own supply to stock the resident's room, they indicated that this was not their facility's protocol.

In an interview with Acting SOC #129, they indicated that the facility's protocol was to provide one continence product per resident per day and advised the family that they were responsible for providing any extra on top of that.

B) Resident #025's documented plan of care included the use of continence products. In interviews with PSW's #140, #142 and #143, they indicated that the home supplied some of the continence products and the family supplied the remainder.

Resident #025's SDM was interviewed in which they indicated that they were told by the home that they were only obligated to provide one continence product per resident per day. Due to this, the SDM began purchasing products for the resident.

The SOC acknowledged that the resident's SDM's were purchasing additional continence products for residents who required their use based on their assessed needs and plans of care. [s. 91. (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 The licensee must ensure that they do not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf, to be implemented voluntarily.

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 failed to ensure drugs were stored in an area or a medication cart that was secure and locked.

The Long Term Care Homes (LTCH) Inspector observed a medication cart on a home area to be unattended and unlocked. There were residents independently walking directly in front of the medication cart. The registered staff was observed in the dining room, assisting with clean up with her back to the medication cart and general area.

The home's policy "Medication Administration General", policy #LTC9-05.12.01 with a revised date of May 11, 2015, directed staff to ensure the medication cart was locked at all times when not in use.

After approximately five minutes, RPN #100 noticed the LTCH Inspector standing at the medication cart and walked toward them. The RPN did not lock the cart.

The LTCH Inspector interviewed the registered staff responsible for the medication administration for the home area. RPN #100 was asked what the protocol was when leaving the medication cart unattended. They informed the LTCH Inspector they were expected to lock the medication cart at all times when not in use.

The licensee failed to ensure the medication cart was secure and locked. [s. 129. (1) (a)]

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 The licensee must ensure drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

The LTCH Inspector observed an unattended, unlocked medication cart with the Medication Administration Record (MAR) screen open, just outside of the dining room. One resident was wandering around and near the cart. The nurse was observed with her back to the cart, cleaning up the dining room while a few residents finished their meal.

The MAR was open and visible to those around the cart and contained information about a particular resident and their medications and treatments as well as room location, allergies and medical diagnosis.

After approximately three minutes, RPN #100 turned and saw the Inspector and walked toward the medication cart. There was no attempt to lock the cart or close the screen until asked what the expected protocol was when the medication cart was left unattended. RPN #100 informed the LTCH Inspector they were expected to lock the cart and close the MAR screen prior to stepping away from it.

RPN #100 acknowledged they had not protected the personal health information of all residents. [s. 3. (1) 11. iv.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a personal assistive services device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

a) Resident #012 was observed by the LTCH Inspector seated using identified equipment in a specific manner. PSW #116 confirmed that the resident used this

equipment daily as a PASD.

In an interview with the Physiotherapist (PT), they confirmed that the resident was assessed for the use of the PASD and acknowledged that the use of the PASD was not included in the resident's documented plan of care.

In an interview with Supervisor Of Care (SOC) #115, they acknowledged this and confirmed that the PASD should have been included in the resident's documented plan of care. [s. 33. (3)]

b) Resident #024's bed was observed with safety equipment engaged on the bed.

In an interview with SOC #115 and Acting SOC #129 they confirmed that the resident used the equipment for bed mobility and positioning.

A review of the resident's documented plan of care did not include the use of the equipment.

SOC #115 confirmed that the equipment was not included in the resident's documented plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute-decision maker (SDM) of the resident with authority to give that consent.

Resident #012 was observed by the LTCH Inspector using identified equipment. PSW #116 confirmed that the resident used the equipment as a PASD daily.

In an interview with the PT they confirmed that the resident was assessed for the use of the PASD.

The resident's health record was reviewed and did not include informed consent from the SDM. This was confirmed by SOC #115 in an interview. [s. 33. (4) 4.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond to the Family Council in writing within 10 days of receiving a concern from Family Council.

During the interview of the Family Council representative, it was brought forward that the home does not supply the Family Council with written responses within 10 days of receiving a complaint. The Family Council representative stated they were able to review the written responses to concerns at the meeting following the date of the concern.

The Long-Term Care Homes (LTCH) Inspector reviewed the Family Council minutes. The minutes included a form entitled "Concerns/suggestions Sheet" for either Resident's or Family Council dated September 19, 2017.

On September 19, 2017, the Family Council presented a concern to the home regarding a continued shortage of PSW staff on two specific home areas. They requested to be informed of the strategies the home followed to address the situation. The back of the document had a response date of September 29, 2017 and the signature of the Administrator. The Director of Care signed the form under the department supervisor actions. The follow up with Family Council was dated as October 17, 2017, and signed by the Social Worker and the representative of Family Council.

During an interview with the Social Worker, the Family Council's designated assistant, assigned by the home, they told the LTCH Inspector they had telephoned the Family Council representative on September 29, 2017, to review the response. On October 17, 2017, they were shown the written document and asked it to be signed.

The Social Worker was not aware of the home's policy when asked or the requirement under the legislation to respond in writing within 10 days of receipt of the concern. [s. 60. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in section 115 of the Act.

The Director of Care (DOC) provided the home's "Home Specific Evaluation Tool – Medication Management System" dated April 18, 2017.

The Long-Term Care Homes (LTCH) Inspector reviewed the document provided and noted the home did not review the home's quarterly evaluations from the previous year.

During an interview with the DOC, they acknowledged the home did not review the quarterly evaluations from the previous year at the annual evaluation of the medication management system held April 18, 2017. [s. 116. (3)]

Issued on this 14 day of August 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North,
WATERLOO, ON, N2L-4E9
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WATERLOO, ON, N2L-4E9
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Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by HEATHER PRESTON (640) - (A1)

Inspection No. / No de l'inspection : 2018_724640_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005221-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 18, 2018;(A1)

Licensee / Titulaire de permis : The Regional Municipality of Peel
7120 Hurontario Street, 6th Floor, MISSISSAUGA, ON, L5W-1N4

LTC Home / Foyer de SLD : Tall Pines Long Term Care Centre
1001 Peter Robertson Blvd., BRAMPTON, ON, L6R-2Y3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Rejane Dunn

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To The Regional Municipality of Peel, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of the LTCHA.

Specifically the licensee must:

a) Ensure that staff are compliant with the use of Personal Protective Equipment (PPE) as required.
b) Re-education of all nursing staff on Mayfield and Pinerose home areas related to required Infection Prevention and Control (IPAC) measures when isolation precautions are in place, the use of PPE and hand hygiene.
c) A record of attendance at the education is to be kept by the home to include the IPAC topics included in the training.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff participated in the implementation of the Infection prevention and control program.

1) On a specified date in March, 2018, Long-term Care Homes (LTCH) Inspectors #586 and #695 observed a contact precautions sign posted outside of a resident room. The contact precautions sign stated that gloves and gowns must be used while providing resident care.

Gowns and masks were found in the personal protective equipment (PPE) cart

outside the room however, gloves were not found in the cart or inside the resident's room.

LTCH Inspector #695 reviewed the clinical record and found the written plan of care directed staff are to use contact precautions for the provision of direct care.

The home's policy "Infection Prevention and Control Program", policy # LTC8-08.04 with a revised July 30, 2014, stated that residents identified as positive for ESBL Class A should be placed on contact precautions "for the provision of direct care." In the home's "Infection Prevention and Control Program", policy #LTC8-03.08 with a revised date of November 8, 2017, it directed that when residents were on contact precautions, "gloves and gowns must be used for direct contact with the resident or their environment, including objects and equipment in this environment."

On a specified date in March 2018 resident #013 verbalized they required care to LTCH Inspector #640 who informed Personal Support Worker (PSW) #102. PSW #102 was observed taking a mechanical lift and going to the residents room. PSW #102 entered resident #013's room without donning a gown or gloves.

RPN #104 was asked by the LTCH Inspectors what the expectation of PPE use related to the provision of care for this resident. RPN #104 informed the LTCH Inspectors that all staff who provided direct care must wear both gown and gloves.

During an interview with RPN #104 with the LTCH Inspector, they acknowledged that the two PSWs failed to don PPE as required to prevent the transfer of infection.

2) On a specific date in April 2018, the LTCH Inspector observed the following related to resident #015 on contact precautions;

a) PSW #109 was observed in a resident room on isolation precautions, leaning against the resident bed and removing items from the breakfast tray and taking the resident's tray away. The PSW was not wearing gloves or gown. When they left the room, the Long-Term Care Homes (LTCH) Inspector did not observe the staff perform hand hygiene.

The home's policy "Routine Practices - Hand Hygiene", policy #LTC98-03.01 with a revised date of May 9, 2016, directed staff to perform hand hygiene before and after providing resident care.

The home's policy "Routine Practices - Additional Precautions", policy #LTC8-03.08, with a revised date of November 8, 2017, directed staff in addition to routine practices, contact precautions included the donning of gloves and gowns for direct contact with the resident or their environment including objects and equipment in their environment.

The same PSW re-entered the room with another food item for the resident. The PSW did not perform hand hygiene nor don gown and gloves prior to entering the room. They were touching the bed and the resident's over bed table. The PSW left the resident room and did not perform hand hygiene.

b) PSW # 137 was observed entering a resident room on isolation precautions, leaning against the resident bed and removing items from the over bed table and had put their hand on the resident's bed rail. The PSW was not wearing gloves or gown. When they left the room, the Long-Term Care Homes (LTCH) Inspector did not observe the staff perform hand hygiene.

The home's policy "Routine Practices - Hand Hygiene", policy #LTC98-03.01 with a revised date of May 9, 2016, directed staff to perform hand hygiene before and after providing resident care.

The home's policy "Routine Practices - Additional Precautions", policy #LTC8-03.08, with a revised date of November 8, 2017, directed staff in addition to routine practices, contact precautions included the donning of gloves and gowns for direct contact with the resident or their environment including objects and equipment in their environment.

The same PSW re-entered the room with another item for the resident. The PSW did not perform hand hygiene nor don gown and gloves prior to entering the room. They were touching the bed and the resident's over bed table and repositioned the resident's left arm. The PSW left the resident room and did not perform hand hygiene.

During an interview with the Director of Care (DOC), they stated it was an expectation of the home that all staff follow the requirements of wearing gowns and gloves when direct contact with the resident or their equipment was expected. The DOC acknowledged the PSWs had not followed the expected practice. [s. 229. (4)]

The severity of this issue was determined to be a level of minimal harm or potential for actual harm (2), a scope of pattern (2) and a compliance history of previous related non-compliance (3) that included:

i) Written Notification issued November 9, 2015, (2015_301561_0022) (640)

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

Sep 21, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) (b) (iv) of the LTCHA. Specifically the licensee must:

Ensure that residents #009 and #010, and any other resident, are assessed weekly as required by the Act.

Grounds / Motifs :

1.

1. The licensee failed to ensure a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a specified date in March 2018, resident #003 was observed to have altered skin integrity.

The home's policy "Skin and Wound Care Program" with a revised date of June 27, 2016, directed Personal Support Workers (PSW) to observe the resident's skin daily and report any reddened areas or other areas of concern to the registered staff. The registered staff were directed that when a new area of altered skin integrity, which also included eczema, rash and abnormal skin lesion, to complete a Skin and Wound assessment in the assessment tab of PointClickCare (PCC), the home's electronic documentation system.

The LTCH Inspector reviewed the resident's clinical record which revealed the resident had not been assessed for the altered skin integrity.

During an interview with PSW #114, they told the LTCH Inspector that during bath days, the PSW trimmed resident #003's fingernails. PSW staff were to notify the registered staff if skin issues were observed. PSW #114 could not remember how long the resident had the altered skin integrity.

The LTCH Inspector interviewed RPN #108 who was unable to find any skin assessment related to the altered skin integrity in the clinical record. They told the LTCH Inspector the skin assessment was to be completed upon admission and with any skin concerns.

During an interview with Supervisor of Care #115, the Skin and Wound Care Lead for the home, they informed the LTCH Inspector that it was an expectation of the home that PSW staff inform the registered staff when any areas of altered skin integrity were observed. It was expected that the registered staff complete a Skin and Wound assessment and notify the physician. Registered staff were expected to revise the plan of care to include the altered skin integrity and implement interventions appropriate for the skin concern.

The severity of this issue was determined to be a level of minimal harm or potential for actual harm (2), a scope of pattern (2) and a compliance history of "ongoing non-compliance despite previous action taken by the ministry (4) that included:

i) Compliance Order (CO) issued January 27, 2016, (2015_301561_0022) with a compliance due date of April 15, 2016.
ii) Written Notification issued January 5, 2017, (2017_546585_0001)
(606)

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

Aug 24, 2018

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. 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 :

(A1)
The licensee must be compliant with s. 90 (2) (k) of the LTCHA.

Specifically the licensee must:
a) Put in place a system to ensure that all areas where residents have access to hot water, are randomly monitored every shift.
b) A record is to be kept of the water temperature monitoring.
c) Develop and implement an auditing process to ensure hot water procedures are being followed in the home.

Grounds / Motifs :

1. The licensee failed to ensure the water temperature was monitored once per shift in random locations where residents had access to hot water.

During an interview with the Resident's Council, they informed the Long-Term Care Homes (LTCH) Inspector that they and others had experienced no hot water during their bath/shower times over the past several months. They had reported this at their Council meetings.

The home's policy "Water Supply, Water Temperature and Back-Flow Prevention Device", policy #LTC6-06.18 with a revised date of March 27, 2018, directed the In-Charge Nurse/designate to check water temperatures using a digital thermometer at random locations from a water source. If the temperature exceeded 49 degrees Celsius (C), staff were to immediately notify Facility Services staff. The attached "Hot Water Temperature Audit" form directed staff to document a water temperature at a resident faucet on each shift and notify maintenance staff if the temperature was less than 41 degrees C or more than 49 degrees C.

The LTCH Inspector requested the home's record of water temperatures from the Supervisor Facility. The Supervisor Facility gave the LTCH Inspector a file folder containing records of water temperatures for the third floor home areas for the months of January, February and March 2018.

The following was noted by the LTCH Inspector:

- On 18 occasions during the three months on one home area, the water temperatures were not documented.

- On three occasions on one home area, the water temperatures in three resident rooms was documented in excess of 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.
- On three occasions on one home area, the water temperatures in three resident rooms was below 40 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.
- On 24 occasions on one home area, the temperatures were not documented.
- On three occasions staff documented there was no hot water to test. There were no corresponding maintenance work orders to verify that staff reported this to Facility Services staff.
- On six occasions on one home area, water temperatures were documented in excess of 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported this to Facility Services staff.
- On seven occasions on one home area, water temperatures were documented below 49 degrees C. There were no corresponding maintenance work orders to verify that staff reported the temperatures to Facility Services staff.

The LTCH Inspector reviewed the documentation as given by the Supervisor Facility (FS) and there were water temperatures taken from resident rooms on only two of six resident home areas.

The SF went on to explain that the home only monitored water temperatures on the third floor as the water all went up the system to that area, therefore there was no reason to check the water temperatures on each floor.

During an interview with RPN # 107, they informed the LTCH Inspector they had two digital thermometers for water temperature monitoring and both were not functioning. They document a resident room basin on their shift and document it on the audit form.

During an interview with the SF and Supervisor of Care (SOC) #144 regarding the Hot Water Temperature Audit forms, they both acknowledged that staff were not following policy regarding the taking and documentation of the water temperatures, the documentation of action taken and were not always reporting water temperatures when out of range. The SOC and the SF informed the LTCH Inspector that there was no process in place for any review, auditing or follow up related to the Hot Water Temperature Audit forms.

During an interview with Maintenance personnel #139, they informed the LTCH Inspector they calibrated the digital thermometer for monitoring water temperatures by removing and replacing the battery and had done so that morning. The LTCH Inspector took the temperature of a cup of warm water using the newly calibrated LTCH Inspectors digital thermometer and the home's digital thermometer. The home's digital thermometer was 8.88 degrees Celsius lower than the LTCH Inspector's digital thermometer which had been calibrated using the ice water method and zeroed out earlier in the day.

The SF acknowledged the home did not routinely calibrate their equipment nor randomly monitor water temperatures once per shift where residents had access to hot water. [s. 90. (2) (k)]

The severity of the scope was determined to be minimal harm or potential for actual harm (2). The scope was widespread (3) and the compliance history was previous non-related non-compliance in the previous three years.

(640)

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

Jul 20, 2018(A1)

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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 14 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by HEATHER PRESTON - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central West