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 #/ Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016;	2016_264609_0012 (A1)	008907-16	Resident Quality Inspection

Licensee/Titulaire de permis

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extension has been requested by the home

Issued on this 17 day of August 2016 (A1)

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

Original report signed by the inspector.

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CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): April 4-8 and April 11-15, 2016.

This inspection included a Follow-up intake on one compliance order issued during a previous inspection (#2015_332575_0013) related to unclear direction in the plans of care of residents. One Complaint intake related to the home's ventilation system, as well as 13 Critical Incident intakes the home submitted related to staff to resident abuse, resident to resident abuse, falls and an infectious outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DONPC), Acting Assistant Director of Nursing (AADON), Educator, Physiotherapist, Infection Control Lead (ICL), Manager of Environmental Services (MES), Social Worker (SW), Food Services Manager (FSM), Recreational Therapist, Food Service Workers (FSWs) staff, Registered Nursing (RNs) staff, Registered Practical Nursing (RPNs) staff, Personal Support Workers (PSWs) staff, residents and family of residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed numerous licensee policies, procedures, and programs, complaint logs, internal investigations, relevant health care records, staffing schedules, human resource files, training logs and council meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Training and Orientation

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

16 WN(s)
14 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 6. (1)	CO #001	2015_332575_0013	609

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 the written plan of care for each resident set out the planned care for the resident.

Inspector #628 observed three identified residents all with a specified device applied to their bed system.

A review of the current plans of care for the three identified residents revealed two of the three plans or 66 per cent did not mention the specified device.

In an interview with the DONPC, they confirmed that it was the expectation of the home that the plan of care set out the planned care for every resident. The DONPC

also confirmed that in the case of two of the three residents cited with no mention of the specified device, this did not occur. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director in March 2016 which outlined an incident between two identified residents.

Inspector #609 reviewed the current responsive behaviours plan of care for one of the identified residents, which revealed, a progress note was entered into the plan of care as an intervention.

In an interview with the DONPC, they confirmed that the cited intervention in the plan of care for one of the identified residents did not give clear direction to staff related to the resident's responsive behaviours. [s. 6. (1) (c)]

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

During the inspection an identified resident was found to have had a fall within a specified time frame.

On a particular day, Inspector #628 observed the identified resident sitting in a recliner.

A review of the current plan of care for the identified resident revealed that the resident required a specified intervention be applied when sitting in a recliner.

In interviews with registered and personal support staff they confirmed that the identified resident required a specified intervention when in a recliner and that it should have been applied.

In an interview with the DONPC, they confirmed that it was the expectation of the home that the care set out in the plan of care provided to the resident was to have been as specified in the plan. The DONPC also confirmed that in the case of no application of a specified intervention when the identified resident was in a recliner, this did not occur. [s. 6. (7)]

4. A CIS report was submitted to the Director in October 2015 regarding staff abuse of an identified resident who was displaying responsive behaviours.

Inspector #575 reviewed the current plan of care for the identified resident, which revealed that when the resident became resistive to care and when they displayed responsive behaviours, the staff were to leave and return when the resident settled and if needed have a different staff member attempt care.

In interviews with registered staff members they confirmed that when the resident was resistive to care, staff were to leave and return at a later time. They also confirmed that in the case of the incident cited in the October 2015 CIS report, this did not occur. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

On particular days, Inspector #609 observed an identified resident poorly groomed and in an unclean physical state.

A review of the bathing record for the identified resident revealed that for a two week time frame the identified resident should have received four baths. One of the four baths or 25 per cent did not have any documentation to support that the bath was completed.

A review of the home's policy titled "Assessment/Documentation" last revised March 2016 revealed that the interdisciplinary team should have documented the provision and outcomes of the care set out in the care plan.

In an interview with the DONPC, they confirmed that the identified resident was provided a bath but that the PSW did not document that they had completed the care. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the plan of care for identified residents were reviewed and revised at any time when their care needs changed or care set out in the plan was no longer necessary.

Inspector #609 reviewed the plan of care for an identified resident, which indicated that a defined set of interventions was to be implemented when the identified resident was in bed.

Observations of the identified resident on a particular day, revealed the resident in bed with none of the defined set of interventions implemented.

In an interview with the DONPC, they confirmed the inspector's observations of the bed belonging to the identified resident, that the plan of care related to the bed had changed and that the plan of care for the identified resident was not revised. [s. 6. (10) (b)]

7. Inspector #609 reviewed the plan of care for an identified resident, which revealed that depending on the time of day a specified intervention was to be used by staff for transfers and toileting.

In an interview with registered and personal support staff, they revealed the physical strength of the identified resident had improved and no longer required the specified intervention by staff.

In an interview with the DONPC, they confirmed that it was the expectation of the home that when the care needs of a resident changed that the plan of care should have been reviewed and revised and that is did not occur for the identified resident. [s. 6. (10) (b)]

8. On a particular day, Inspector #575 observed a registered staff member administer medication to an identified resident.

In an interview with the registered staff member, they revealed that the medication times for the identified resident were incorrect related to the resident's defined daily routine but required a physician to change them.

A review of the plan of care for the identified resident did not specify that the resident had a defined daily routine related to their preferences which altered the timing of the resident's medications.

In an interview with registered staff, they confirmed the identified resident's defined daily routine altered the resident's medication timing.

A review of the electronic medication administration record (eMAR) for the identified resident for a particular time frame revealed multiple incidents of medications given to the resident outside of the specified administration times. [s.

6. (10) (b)]

9. A CIS report was submitted to the Director in June 2015 which indicated that an identified resident had fallen on a particular day, which resulted in an injury.

Inspector #609 reviewed the current plan of care for the identified resident, which revealed that due to the injury required defined interventions and treatment.

Observations of the identified resident on a particular day revealed the resident without any of the defined interventions or treatment.

In an interview with registered staff, they confirmed that the identified resident had recovered from the injury and did not require the defined interventions or treatment any longer.

A review of the health care records for the identified resident revealed that as of a particular day the resident had recovered from the injury.

In an interview with the DONPC, they confirmed that there was nearly a full year since the resolution of the identified resident's injury with no revision in the resident’s plan of care related to their improved status. [s. 6. (10) (b)]

10. Inspector #575 observed an identified resident seated in the main dining room during a meal service.

A review of the plan of care for the identified resident indicated staff were to implement a specific intervention with the resident to manage responsive behaviours during meal services.

A review of the health care records for the identified resident revealed a physician note that indicated the resident's responsive behaviours had improved now and that staff were no longer required to implement the specific intervention during meal services.

In an interview with registered staff, they confirmed that the plan of care for the identified resident was not updated after the physician's note. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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.

Inspector #628 observed three identified residents, all with a specified bed rail applied to their bed systems.

In an interview with the DONPC, they indicated that the bed system was assessed annually by an external contracted assessor and that the bed assessments for the three identified residents were completed prior to the bed systems being modified with the specified bed rail. The DONPC also confirmed that there was no reassessment of the beds for the three identified residents after the specified intervention was applied to their bed systems. [s. 15. (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 to ensure that where bed rails are used, 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director in March 2016 that contained allegations of staff to resident abuse. The CIS described an incident whereby personal support staff were observed to physically abuse an identified resident. The CIS also described how other staff members knew and did not immediately report the allegations of abuse to the Nurse Manager.

A review of the home's policies titled 'Abuse Policy – Investigation' and 'Abuse Policy– Definition' last revised December 2015 revealed that any person who had reasonable grounds to suspect an instance of abuse must immediately report the concern to the Nurse Manager or a member of the Leadership Team. The policies also outlined that any behaviour or conduct that was detrimental to the resident would not have been tolerated.

In an interview with the DONPC, they confirmed that a member of the personal support staff abused the identified resident and that another member of the personal support staff did not immediately report the allegations and the information upon which it was based to their manager. The DONPC also confirmed that in the case of the physical abuse suffered by the identified resident and the lack of immediate reporting, the staff did not comply with the home's policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone,
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the Regulation.

During the inspection three allegations of abuse were brought forward by residents to Inspector #575.

On a particular day, the DONPC was advised of the three cited allegations of abuse.

A review of the home's policy titled "Abuse Policy – Investigation" last revised December 2015 indicated that an investigation into allegations of abuse would have been immediate, that the resident would have been interviewed, the individual accused of the abuse would have been interviewed, a follow-up interview with potential witnesses may have been arranged, and a final interview would have been conducted.

In a follow up interview with the DONPC, they confirmed that they interviewed the three identified residents in the allegations of abuse six days after they were advised of the allegations of abuse. The DONPC revealed that they did not complete the home's alleged abuse reporting form as outlined in the home's policy. [s. 23. (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 to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the Director in October 2015 regarding allegations of staff to resident abuse. The incident outlined in the CIS occurred at a specific time.

Inspector #575 reviewed the home's internal investigation of the cited incident revealed that the previous DONPC received a letter from a registered staff member at a specific time alleging staff to resident physical abuse.

A review of the internal investigation was conducted with the current DONPC who confirmed a gap of nearly 24 hours between when they became aware of the cited incident and the report to the Director and that this should not have occurred. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A CIS report was submitted to the Director in September 2015 which described an incident whereby a staff member altered an identified resident's environment in a specified manner while the resident was calling out to staff during a night shift.

In interviews with registered and personal support staff they indicated to Inspector #609 that the alteration of the resident's enviroment by the staff member should not have occurred related to the identified resident's sleep patterns and preferences.

A review of progress notes for the identified resident revealed that on a particular day a staff member altered the identified resident's environment in a manner that they should not have done which caused the resident to become responsive. The progress notes confirmed that the resident was previously assessed by registered staff and that staff were not to alter the resident's environment in the manner cited.

A review of the plan of care for the identified resident revealed no direction to staff to have ensured that they did not alter the resident's environment in the manner specified.

In an interview with the DONPC, they confirmed that it was the expectation of the home that the plan of care for a resident should have been based on the assessment information of the resident’s sleep patterns and preferences. The DONPC also confirmed that in the case of the cited assessed sleep patterns and preferences for the identified resident that were not within the resident’s plan of care, the home was not in compliance with the Act and should have been. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences, 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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, a written record was kept related to each annual evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A CIS report was submitted to the Director in June 2015 which indicated that an identified resident had fallen on a particular day that resulted in an injury and a significant change in the resident's health condition.

The home was unable to provide Inspector #609 with a written record of the Fall Prevention program annual evaluation.

In an interview with the DONPC, they indicated that as part of the quarterly Falls Committee meetings the program was evaluated once a year during a quarterly meeting, but acknowledged that there was no written record of the annual evaluation of the Falls Prevention program.

In interviews with the Administrator and the DONPC, they both confirmed that there was no written record kept of the annual evaluation of the Falls Prevention program. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, a written record is kept related to each annual evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented specifically in regards to the Falls Prevention Program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

On particular days, Inspector #609 observed at various times of the day an identified resident sitting in the hallway poorly groomed.

A review of the plan of care for the identified resident revealed that they were to be provided with specific grooming activities daily.

Observations made on another particular day revealed the identified resident significantly unclean while sitting in the hallway.

In an interview with registered staff, they confirmed that the resident was to have been ready for meal service at the time of the observations and that the grooming did not occur.

In an interview with personal support staff, they confirmed that they were present and working the morning of the cited observations and revealed that the care was not provided related to the responsive behaviours of the identified resident and that they attempted to complete care alone.

A review of the plan of care for the identified resident revealed that that the resident required more than one staff member to assist with care.

In an interview with the DONPC, they confirmed that it was the expectation of the home that residents were to have received individualized personal care, including hygiene care and grooming on a daily basis and that this did not occur for the identified resident on the particular days indicated above. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident receives individualized personal care, including hygiene care and grooming on a daily basis, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

On particular days, Inspector #609 observed an identified resident with long, untrimmed fingernails and debris noted underneath.

In an interview with personal support staff, they confirmed the above observations made by the inspector and further indicated that the resident's nails should have been cleaned and trimmed twice a week during the resident's bathing routine.

A review of the health care records for the identified revealed they were to be provided with two baths between a specific time frame, at which time the resident's fingernails were to have been cleaned and trimmed.

A review of the home's policy titled "Activities of Daily Living - RSL-ADL-005" last revised June 2014 indicated that residents were to have received nail care as part of their regular bathing routine two times per week.

A review of the plan of care for the identified resident revealed their fingernails were to have be cleaned daily as part of their personal grooming routine.

In an interview with the DONPC, they confirmed the inspector's observations. [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

On a particular day, Inspector #628 observed that three of the four or 75 per cent of the home's spa rooms had various unlabelled personal items left unattended.

These personal items included but were not limited to hairbrushes with hair noted on them as well as tubes of used lipstick.

In an interview with the ICL for the home, they confirmed that it was the expectation of the home that all personal items were to have been labelled within 48 hours of admission and on acquiring new items. [s. 37. (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 to ensure that each resident of the home has his or personal items labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

In interviews with three identified residents, they all revealed to Inspector #609 that at times soup was served to them cold.

Observations of the lunch meal service on two particular days on an identified unit revealed that soup was dished and placed onto a rolling cart. Soup was then offered and served to each resident as the cart made its way around the dining room.

The temperature of the soup immediately after the last resident was served on one of the particular days was 69.2 degrees Celsius.

A review of the home's "Servery Daily Temperature Audit" sheet revealed that soup was to have been served at a temperature between 71 and 82 degrees Celsius.

In an interview with the FSM, they confirmed that it was the expectation of the home that all residents were to have been served soup between 71 and 82 degrees Celsius. The FSM acknowledged that the soup temperature was taken at the time of dishing, but as a result there was no way to have ensured that the last residents being served soup would have received hot soup. The FSM also confirmed that the same procedure was used for all units of the home. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned.

A Complaint was submitted to the Director in October 2015 which alleged that the air ventilation system for the home was not being properly cleaned and maintained.

On a particular day, Inspector #609 observed the return vents of on an identified unit with significant dust and debris clogging the return vent covers.

These observations were confirmed by the acting Manager of Environmental Services (MES).

A review on a particular day of all 12 return vents in the common areas of the identified unit revealed eight or 66 per cent had significant dust and debris clogging the return vent covers.

In an interview with the Administrator, they confirmed that it was the expectation of the home that the ventilation and air conditioning systems were routinely cleaned. The Administrator acknowledged that neither the home's housekeeping nor maintenance departments had procedures in place for the routine cleaning of the air vents inside the home. [s. 90. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that the heating, ventilation and air conditioning systems are cleaned, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporated the requirements set out in section 101 of the Regulation whereby a complaint would be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation would be commenced immediately.

During the inspection, three allegations of improper care were revealed and reported by Inspector #575 to the DONPC who did not immediately act upon the information provided.

The Inspector requested to review the home’s complaint policy and procedures. The DONPC provided the inspector with the home’s policy titled "Questions/Concerns/Suggestions" last revised February 2016.

A review of the policy revealed no outline of the requirements as specified in the Regulation. Specifically, the policy did not provide time frames for actions to be taken, the investigation process, or the home’s required responses to both written and verbal complaints.

A review of the home’s policy was conducted with the DONPC who confirmed that the policy did not comply with the requirements as set out in section 101 where the complaint that alleged harm or risk of harm to one or more residents should have been investigated immediately. [s. 100.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written procedures required under section 21 of the Act incorporated the requirements set out in section 101, specifically that the home's policy provides time frames for actions to be taken, the investigation process and the home's required responses to both written and verbal complaints, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A CIS report was submitted to the Director in June 2015 which indicated that an identified resident had fallen on a particular day that resulted in injury.

The CIS was submitted to the Director five business days after the incident occurred.

The Act defines a significant change in a resident's health condition as not resolved without further intervention, impacted on more than one aspect of the resident's health condition, and required an assessment by the interdisciplinary team or a revision to the resident's plan of care.

In an interview with the DONPC, they acknowledged that the injuries diagnosed and the resulting changes to the care of the identified resident qualified as a significant change. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart,
i. that was used exclusively for drugs and drug-related supplies,
ii. that was secure and locked,
iii. that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
iv. that complied with manufacturer's instructions for the storage of the drugs.

In an interview with Inspector #575, registered staff revealed that PSWs applied topical medications under the supervision of the registered staff. They stated that topical medications were stored in a bin that was provided to the PSWs at the start of their shift and then returned to the RPN at the end of their shift or when they were done with them. Registered staff indicated that the bin was stored during the day in a locked file cabinet.

The inspector observed the filing cabinet located in the nursing station with registered staff who were observed to open the filing cabinet without a key and that it contained several topical medications.

A review of the home’s policy titled “Safe Storage of Medications” last revised June 2014 outlined that "external medications may be stored in a separate cupboard within the medication room, separate drawer of the medication cart, or treatment cart".

In an interview with the AADON, they confirmed that it was the expectation of the home that topical medications were to have been returned to the RPN immediately after administration by the PSWs and that topical medications were to have been stored in a locked medication room. [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 to ensure that 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, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there was no Family Council established in the home, the licensee convened semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

In an interview with Inspector #575, the home's Social Worker (SW) revealed that the home did not currently have a Family Council. The SW explained that the home had a Family Auxiliary that meets eight times per year, and twice per year they vote if they would like to become a Family Council. The SW confirmed that the home did not currently convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 17 day of August 2016 (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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHAD CAMPS (609) - (A1)

Inspection No. / No de l'inspection : 2016_264609_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008907-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 11, 2016;(A1)

Licensee / Titulaire de permis : LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

LTC Home / Foyer de SLD : LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LEN FABIANO

To LAKELAND LONG TERM CARE SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

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

The licensee shall:

Perform a review of the plan of care for every resident in the home to ensure that the care outlined is up to date and accurate to the resident's current health status, including but not limited to specifically ensuring that:

i) An identified resident's plan of care accurately identifies all responsive behaviours, triggers and interventions to assist staff in the management of the resident's behaviours.

ii) An identified resident's plan of care accurately identifies all their physical, ambulatory and care needs in order for staff to provide up to date care.

iii) An identified resident's plan of care accurately identifies how staff are to manage the resident's medication administration and nutrition impacted by the resident's current sleep preferences.

iv) An identified resident's plan of care accurately identifies all their physical, transfer and care needs in order for staff to provide up to date care.

v) An identified resident's plan of care accurately identifies all skin, wound and bed related care needs in order for staff to provide up to date care.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care for identified residents were reviewed and revised at any time when their care needs changed or care set out in the plan was no longer necessary.

Inspector #575 observed an identified resident seated in the main dining room during a meal service.

A review of the plan of care for the identified resident indicated staff were to implement a specific intervention with the resident to manage responsive behaviours during meal services.

A review of the health care records for the identified resident revealed a physician note that indicated the resident's responsive behaviours had improved now and that staff were no longer required to implement the specific intervention during meal services.

In an interview with registered staff, they confirmed that the plan of care for the identified resident was not updated after the physician's note. (575)

2. A CIS report was submitted to the Director in June 2015 which indicated that an identified resident had fallen on a particular day, which resulted in an injury.

Inspector #609 reviewed the current plan of care for the identified resident, which revealed that due to the injury required defined interventions and treatment.

Observations of the identified resident on a particular day revealed the resident without any of the defined interventions or treatment.

In an interview with registered staff, they confirmed that the identified resident had recovered from the injury and did not require the defined interventions or treatment any longer.

A review of the health care records for the identified resident revealed that as of a particular day the resident had recovered from the injury.

In an interview with the DONPC, they confirmed that there was nearly a full year since the resolution of the identified resident's injury with no revision in the resident's plan of care related to their improved status. (609)

3. On a particular day, Inspector #575 observed a registered staff member administer medication to an identified resident.

In an interview with the registered staff member, they revealed that the medication times for the identified resident were incorrect related to the resident's defined daily routine but required a physician to change them.

A review of the plan of care for the identified resident did not specify that the resident had a defined daily routine related to their preferences which altered the timing of the resident's medications.

In an interview with registered staff, they confirmed the identified resident's defined daily routine altered the resident's medication timing.

A review of the electronic medication administration record (eMAR) for the identified resident for a particular time frame revealed multiple incidents of medications given to the resident outside of the specified administration times. (575)

4. Inspector #609 reviewed the plan of care for an identified resident, which revealed that depending on the time of day a specified intervention was to be used by staff for transfers and toileting.

In an interview with registered and personal support staff, they revealed the physical strength of the identified resident had improved and no longer required the specified intervention by staff.

In an interview with the DONPC, they confirmed that it was the expectation of the home that when the care needs of a resident changed that the plan of care should have been reviewed and revised and that is did not occur for the identified resident. (609)

5. Inspector #609 reviewed the plan of care for an identified resident, which indicated that a defined set of interventions was to be implemented when the identified resident was in bed.

Observations of the identified resident on a particular day, revealed the resident in bed with none of the defined set of interventions implemented.

In an interview with the DONPC, they confirmed the inspector's observations of the bed belonging to the identified resident, that the plan of care related to the bed had changed and that the plan of care for the identified resident was not revised.

The scope of this issue was determined to have been a pattern of plans of care not reviewed or revised when the resident's care needs changed, a goal in the plan was met, or care set out in the plan had not been effective. During a previous inspection (#2015_332575_0013) a voluntary plan of correction (VPC) was issued to the home on July 22, 2015, related to plans of care not being revised. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents in the home without up to date plans of care. (609)

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

Oct 17, 2016(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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 17 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHAD CAMPS - (A1)

Service Area Office /
Bureau régional de services : Sudbury