Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2016	2016_333577_0007	003347-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

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

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

This inspection includes three complaints regarding skin and wound care, pain management, palliative care, transferring, repositioning and fluctuating water temperatures in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinator, Environmental Services Manager (ESM), Dietary staff, residents and family members.

During the course of the inspection, observations were made of resident home areas, the provision of care and services to residents, staff and resident interactions, reviewed health care records, the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A complaint was received by the Director in January 2016, reporting that the home had water maintenance issues for a few weeks in January 2016.

A review of work orders from an outside service provider revealed that in January 2016, there were labor costs associated with 'building heating and domestic hot water boilers and domestic hot water temperatures'. A work order from January 2016, revealed labor costs associated with 'boiler pump replacement and parts'.

A review of the home's policy titled "Daily Maintenance Audit, ESP-B-05", last revised September 2004, indicated that the home will have established and implemented a recording mechanism for maintenance requirements, as follows:

-record all of the following on the "Daily Maintenance Audit Form - ESP-B-05-05", daily for a period of one month: domestic water return temperature, domestic water storage temperature, heating water return temperature, heating water supply temperature;

-the daily recording log will be kept in the boiler room in close proximity to the mixing valves; and

-readings will be done by the Environmental Services Manager or designate Monday to Friday and the Charge Nurse on weekends.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there were no records of the Daily Maintenance Audit Form and staff were documenting the information on a form 'Hot water tank reading', which reads the water temperature at the source. They further confirmed that staff weren't following the policy.

A review of the "Hot water tank reading" forms revealed inconsistent readings or no readings, on the following dates:

-one day in January 2016: no reading
-one week in February 2016: no reading, "reading still not stable, valve to be installed next week"

-six other days in February 2016: no reading
-three days in March 2016: no reading

A review of home's policy titled "Hot Water Temperature Monitoring - ES-B-90", last revised September 2002, indicated that water temperatures within the residence will be maintained according to legislative and/or company standards. Within the policy, listed under 'procedure' the following was indicated:

-record water temperature daily on the "Hot Water Temperature Record - ES-B-90-05";

-run the tap for three to five minutes and take water temperature samples from different locations; and

-temperatures should not fall below 40 degrees Celsius or exceed 49 degrees Celsius, should temperatures fall outside these ranges, the Executive Director or designate must notify both the ESM/Maintenance and nursing, and corrective action must be taken.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there were no records of completed Hot Water Temperature Monitoring, this procedure wasn't being done and staff weren't following the policy.

During an interview with RPN #106, they reported that water was lukewarm for two weeks in January.

During an interview with PSW #107, they reported that water temperatures were intermittent since February 2016.

During an interview with RPN #108 and PSW #109, they reported that there were issues with lack of hot water beginning in January 2016, and that this occurred for over a month. They further reported that it was intermittent and there were many days and shifts where residents did not receive their tub baths.

During an interview with PSW #110, they reported that in January the water was cold to lukewarm for a couple weeks, and tub baths couldn't be done on day shifts.

During an interview with PSW #111, they reported that over the past year the water temperature had been fluctuating from hot to lukewarm and wouldn't warm up. They further reported there had been several times where residents haven't had their tub bath

twice a week and that after the second or third bath was done, the water became lukewarm.

During an interview with PSW #101, they reported that there were issues with water being lukewarm starting in January 2016, and some days they couldn't do tub baths and would give residents sponge baths. They further confirmed that due to lack of hot water, resident #011 had a sponge bath in January 2016, and resident #012 had a sponge bath in January 2016.

During an interview with PSW #102, they reported that there were three weeks in January where the water was cool, sometimes lukewarm and bed baths had to be done during that time. They further confirmed that due to lack of hot water, residents received bed baths on the following days:

- one day in January 2016: resident #011
- one day in January 2016: resident #013
- one day in January 2016: resident #014
- one day in January 2016: resident #015

During an interview with PSW #117, they reported that the water was cool to lukewarm and due to lack of hot water, residents received bed baths on the following days:

-one day in January 2016: resident #016
-one day in January 2016: resident #007
-one day in January 2016: resident #006
-one day in January 2016: resident #008
-one day in January 2016: resident #010
-one day in January 2016: resident #004
-one day in January 2016: resident #005

During an interview with a family member of resident #010, they reported a time during this winter when the home was having a problem with the boiler and the resident was given a bed bath due to lack of hot water.

During time of inspection, the Inspector found the resident care areas to have hot water.

During an interview with ESM #112, they stated that the home had intermittent hot and cold water temperatures in January and both mixing valves were replaced in March.

They further reported that the fluctuating water temperatures affected the resident care areas and they were never without hot water. They further confirmed that there were no records of the Hot Water Temperature Monitoring forms or Daily Maintenance Audit Forms and staff were not following these policies concerning water temperatures.

During an interview the Executive Director (ED) and Director of Care both reported that the home was never without hot water in January and February. [s. 15. (2) (c)]

2. A review of resident #001's progress notes revealed that in November 2015, the resident's family reported to staff that the resident looked uncomfortable in their chair and had been leaning forward in their chair the previous day and were concerned that they were in pain. Progress notes dated December 2015, revealed that PT #100 found the resident's special seating cushion to be punctured in one of the cell's. Progress notes dated December 2015, revealed that RN #113 found the replacement seating cushion to be flat, with no pressure downloading while the resident was up in their chair. The progress note further indicated that the resident had further altered skin integrity due to pressure from the flat seating cushion.

During an interview with Physiotherapist (PT) #100, they stated that the resident was transferred to a special chair with a seating cushion in September 2015. They further confirmed that the PSW 's are responsible for filling air into the seating cushions and the flat seating cushion contributed to the cause of the altered skin integrity. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(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 failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

A complaint was received by the Director in January 2016, reporting that the home had water maintenance issues for a few weeks in January.

A review of the home's policy titled "Daily Maintenance Audit - ESP-B-05", last revised September 2004, indicated that the home will have established and implemented a recording mechanism for maintenance requirements, as follows:

-record all of the following on the "Daily Maintenance Audit Form - ESP-B-05-05", daily for a period of one month: domestic water return temperature, domestic water storage temperature, heating water return temperature, heating water supply temperature;

-the daily recording log will be kept in the boiler room in close proximity to the mixing valves; and

-readings will be done by the Environmental Services Manager or designate Monday to Friday and the Charge Nurse on weekends.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there are no records of the Daily Maintenance Audit Form and staff were documenting the information on a form "Hot Water Tank Reading", which reads the water temperature at the source. They further confirmed that staff weren't following the policy.

A review of the "Hot Water Tank Reading" forms revealed inconsistent readings or no readings, on the following dates:

-one day in January 2016: no reading
-one week in February 2016: no reading, "reading still not stable, valve to be installed next week"
-six other days in February 2016: no reading
-three days in March 2016: no reading

A review of home’s policy titled “Hot Water Temperature Monitoring - ES-B-90", last revised September 2002, indicated that water temperatures within the residence will be maintained according to legislative and/or company standards. Within the policy, listed under 'procedure' the following was indicated:

-record water temperature daily on the "Hot Water Temperature Record - ES-B-90-05";

-run the tap for three to five minutes and take water temperature samples from different locations; and

-temperatures should not fall below 40 degrees Celsius or exceed 49 degrees Celsius, should temperatures fall outside these ranges, the Executive Director or designate must notify both the ESM/Maintenance and nursing, and corrective action must be taken.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there are no records of completed Hot Water Temperature Monitoring forms and staff were not following these policies concerning water temperatures.

A review of the home's policy titled "Bathing and Showering - LTC-H-40", last revised March 2016, indicated that "at a minimum, 3 water temperature checks shall be performed and recorded for each bath/shower, prior to immersing resident into tub or giving shower. One staff member shall be responsible for running the water, performing and recording the required water temperature checks. Staff were required to document the temperature checks on the "Bath/Shower Temperature Log - LTC-H-40-05".
-Check # 1: check the water temperature while the water is running using the integrated tub thermometer, if available, or a hand-held thermometer;

-Check #2: hold the hand-held thermometer in the water until temperature reading is steady; and

-Check #3: immediately prior to resident entering the water, staff immerses own forearm or holds the inside of their forearm into the water for at least five seconds.

A review of the "Bath/Shower Water Temperature Log - LTC-H-40-05" recorded for each home unit for 2016, indicated inconsistencies in documentation. The following dates indicate when the temperature checks were completed:

Home area #1:

-January 2016: three days
-February 2016: ten days
-March 2016: 12 days, no temperature checks documented under 'Check 2' for 13 baths given

Home area #2:
-January 2016: six days
-February 2016: six days
-March 2016: 16 days

Home area #3:
-no tub temperatures for January-March 2016

Home area #4:
-January 2016: one day
-February 2016: no tub temperature checks
-March 2016: one day

During an interview with ESM #112, they stated that there were no records of the Hot Water Temperature Monitoring forms, Daily Maintenance Audit Forms and staff were not following these policies concerning water temperatures. They further confirmed that there were no other records verifying Bath/Shower Water Temperature log's for 2016. [s. 90. (2) (k)]

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. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the Director in January 2016, reporting that the home did not have consistent hot water for a few weeks in January 2016, and not all residents were receiving tub baths.

A review of the home's policy titled “Bathing and Showering - LTC-H-40", last revised March 2016, indicated that residents will be offered a tub bath or shower at least two times weekly.

During a record review of resident's baths on a home unit, inspector found 40 ‘sponge baths’ recorded for 21 residents, documented the last two weeks of January. A review of residents care plans found that six of those residents preferred tub baths or showers to be given twice a week. 21/32 residents did not have their bathing preference documented in their care plan.

A review of resident #004's care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on three days in January 2016.

A review of resident #005's care plan revealed that showers was their bathing preference. A record review revealed that resident had a sponge bath on two days in January 2016.

A review of resident #006's care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on three days in January 2016.

A review of resident #007’s care plan revealed that showers was their bathing preference. A record review revealed that resident had a sponge bath on two days in January 2016.

A review of resident #008’s care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on one day in

January 2016.

A review of resident #009's care plan revealed that tub baths and showers was their bathing preference. A record review revealed that resident had a sponge bath on one day in January 2016.

A review of resident #010's care plan revealed that a spa bath once a week was their bathing preference. A record review revealed that resident had a sponge bath on one day in January 2016.

During an interview with RPN #108 and PSW #109, they reported that there were issues with lack of hot water beginning in January 2016, and this occurred for over a month. They further reported that the water temperature was not consistently hot and there were many days and shifts where residents didn't get there tub baths.

During an interview with PSW #110, they reported that in January, the water was cold to lukewarm for a couple weeks, and tub baths couldn't be done on day shifts.

During an interview with PSW #111, they reported that over the past year the water temperature has been fluctuating from hot to lukewarm and wouldn't warm up. They also reported there have been several times where residents did not have their tub bath twice a week and that after the second or third bath was done, the water became lukewarm.

During an interview with PSW #101, they reported that there were issues with water being lukewarm starting in January 2016, and some days they couldn't do tub baths and would give residents sponge baths. They further confirmed that due to lack of hot water, resident #011 had a sponge bath on one day in January 2016 and resident #012 had a sponge bath on two days in January 2016.

During an interview with PSW #102, they reported that there were three weeks in January where the water was cool, sometimes lukewarm and bed baths had to be done during that time. They further confirmed that due to lack of hot water, residents received bed baths on the following days:
-one day in January 2016: resident #011
-one day in January 2016: resident #013
-one day in January 2016: resident #014
-one day in January 2016: resident #015

During an interview with PSW #117, they reported that the water was cool to lukewarm and due to lack of hot water, residents received bed baths on the following days:
-one day in January 2016: resident #016
-one day in January 2016: resident #007
-one day in January 2016: resident #006
-one day in January 2016: resident #017
-one day in January 2016: resident #010
-one day in January 2016: resident #004
-one day in January 2016: resident #005

During an interview with a family member for resident #010, they reported a time during this winter when the home was having a problem with the boiler and resident was given a bed bath due to lack of hot water.

During an interview with ESM #112, they confirmed that the home had intermittent hot and cold water temperatures in January and both mixing valves were replaced in March. Reports this affected resident care areas and they were never without hot water.

During an interview with the DOC they confirmed that it was the expectation of the home that residents receive their bathing preference and further confirmed that those residents received sponge baths. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for the resident that sets out the planned care for the resident.

A review of resident #001's care plan revealed the intervention of a special seating surface in December 2015.

During an interview with PT #100, they indicated that resident #001 was transferred to a special chair with a seating surface in September 2015. They further confirmed that in December 2015, they replaced that seating surface with another facility seating surface. In December 2015, the resident received an assessment seating surface from an outside source.

During an interview with the DOC they confirmed that the intervention for a seating surface was not clearly documented in the care plan until late December. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an

assessment of the resident and the needs and preferences of that resident.

During a review of residents care plans on a home unit, Inspector found 21/32 residents that did not have their bathing preference documented in their care plan. Their care plans had no information concerning ‘bathing’ or preference. Inspector reviewed the units ‘Bath Schedules’ and found one resident listed as ‘shower’.

During an interview with PSW #102, they reported that bathing information and preferences should be written in residents care plan.

During an interview with PSW #103, they reported that bath preferences should be documented in the care plan and there aren't any residents who prefer bed baths.

During an interview with the DOC they confirmed that it is the expectation of the home that all residents have their bath preferences documented in their care plans and on the home units ‘Bath Schedule’ sheet. [s. 6. (2)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary.

A review of resident #003's orders revealed that they were having pain issues which began in February 2016, and pain medication was ordered as needed. In March 2016, another pain medication was ordered to be given at regular intervals and the dosage was increased on two other occasions.

A review of the resident's care plan revealed that they had a condition and the nursing focus of pain with interventions was not included in the care plan.

During an interview with RPN #104, they stated that the care plan should include the nursing focus of pain with interventions.

During an interview the DOC they confirmed that resident #003 had pain issues and their care plan should have been updated to include pain interventions. They further confirmed that it was the expectation of the home that care plans be updated when care needs change. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, specifically in regards to resident #001; and the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, specifically in regards to the residents on a particular home area; and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary, specifically in regards to resident #003, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system put into place was complied with.

A review of resident #001's progress notes dated in December 2015, documented that the resident had impaired skin integrity.

A review of the altered skin integrity record revealed that the resident was initially assessed for impaired skin integrity in December 2015. The Inspector reviewed the treatment documentation and noted that the first date documented was in the beginning of December 2015. A review of the altered skin integrity records revealed a deterioration in skin integrity in December 2015 and January 2016.

A review of resident #001's care plan, for December 2015, did not indicate the location of altered skin integrity or interventions to prevent further altered skin integrity.

A review of the home's policy titled "Skin and Wound Program - LTC-E-90", last revised August 2015, indicated that "the Interdisciplinary Skin and Wound Care Team will develop, review and update the resident's care plan goals and interventions in collaboration with the resident/SDM/family to address prevention strategies, skin care and wound management".

During an interview with the DOC, they confirmed that it was the home's expectation that a resident's care plan related to altered skin integrity be clear as to their location and updated. They further confirmed that there was not any documented interventions in the resident's care plan for three weeks in December 2015, for altered skin integrity. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system put into place was complied with, specifically in regards to the Skin and Wound Program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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).

Findings/Faits saillants :

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

A review of the home's policy titled "Skin and Wound Program - LTC-E-90", last revised August 2015, indicated that the Treatment Observation Record (TOR)-Initial Wound Assessment (LTC-E-90) was initiated when a resident has any open area/wound and the Treatment Observation Record (TOR)-Ongoing Wound Assessment (LTC-E-90) was completed with every dressing change, but minimum every seven days.

A review of the altered skin integrity record revealed that resident #001 had impaired skin

integrity. During a review of the assessments from December 2015 to April 2016, the following assessments were missing:

-one area of altered skin integrity: one week in December and one week in January;

-a second area of altered skin integrity: one week in December;

-a third area of altered skin integrity: one week in February;

-a fourth area of altered skin integrity: two weeks in February;

-a fifth area of altered skin integrity: two weeks in February;

-a sixth area of altered skin integrity: two weeks in March; and

-a seventh area of altered skin integrity: two weeks in February and one week in April. [s. 50. (2) (b) (iv)]

2. A review of the altered skin integrity records revealed that resident #003 had altered skin integrity. There were no weekly skin assessments for two weeks in February and a week in March.

During an interview with RN #113, they indicated that an Initial Assessment was done with the discovery of altered skin integrity and an altered skin integrity record was documented once weekly and with every skin treatment.

During an interview the DOC they confirmed with the inspector that an altered skin integrity record was documented once weekly and with every skin treatment. They further confirmed that not all assessments were completed weekly for residents #001 and #003. [s. 50. (2) (b) (iv)]

3. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

A review of resident #003's care plan revealed that the resident required turning every two hours while in bed.

Observations made over a four hour period, on a day in April 2016, revealed the resident positioned on their back on a special mattress with no repositioning from staff.

During an interview with PSW #114 and PSW #115, they both stated that residents on special mattresses needed to be re-positioned from back and side to side every two hours.

During an interview with PSW #116 and RPN #104, they both revealed that residents should be turned/repositioned every two hours when on a special mattress.

During an interview with the DOC they confirmed that it was the expectation of the home that staff reposition/turn residents every two hours on special mattresses. [s. 50. (2) (d)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and 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, to be implemented voluntarily.

Issued on this 13th day of July, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2016_333577_0007
Log No. / Registre no:	003347-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 14, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINEWOOD COURT 2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL GRANT

To REVERA LONG TERM CARE INC., 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.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically in regards to the water heating system in the home.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A complaint was received by the Director in January 2016, reporting that the home had water maintenance issues for a few weeks in January 2016.

A review of work orders from an outside service provider revealed that in January 2016, there were labor costs associated with 'building heating and domestic hot water boilers and domestic hot water temperatures'. A work order from January 2016, revealed labor costs associated with 'boiler pump replacement and parts'.

A review of the home's policy titled "Daily Maintenance Audit, ESP-B-05", last revised September 2004, indicated that the home will have established and implemented a recording mechanism for maintenance requirements, as follows:

-record all of the following on the "Daily Maintenance Audit Form - ESP-B-05-05", daily for a period of one month: domestic water return temperature,

domestic water storage temperature, heating water return temperature, heating water supply temperature;

-the daily recording log will be kept in the boiler room in close proximity to the mixing valves; and

-readings will be done by the Environmental Services Manager or designate Monday to Friday and the Charge Nurse on weekends.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there were no records of the Daily Maintenance Audit Form and staff were documenting the information on a form 'Hot water tank reading', which reads the water temperature at the source. They further confirmed that staff weren't following the policy.

A review of the "Hot water tank reading" forms revealed inconsistent readings or no readings, on the following dates:

-one day in January 2016: no reading
-one week in February 2016: no reading, "reading still not stable, valve to be installed next week"
-six other days in February 2016: no reading
-three days in March 2016: no reading

A review of home’s policy titled “Hot Water Temperature Monitoring - ES-B-90", last revised September 2002, indicated that water temperatures within the residence will be maintained according to legislative and/or company standards. Within the policy, listed under 'procedure' the following was indicated:

-record water temperature daily on the "Hot Water Temperature Record - ES-B-90-05";

-run the tap for three to five minutes and take water temperature samples from different locations; and

-temperatures should not fall below 40 degrees Celsius or exceed 49 degrees Celsius, should temperatures fall outside these ranges, the Executive Director or designate must notify both the ESM/Maintenance and nursing, and corrective action must be taken.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there were no records of completed Hot Water Temperature Monitoring, this procedure wasn't being done and staff weren't following the policy.

During an interview with RPN #106, they reported that water was lukewarm for two weeks in January.

During an interview with PSW #107, they reported that water temperatures were intermittent since February 2016.

During an interview with RPN #108 and PSW #109, they reported that there were issues with lack of hot water beginning in January 2016, and that this occurred for over a month. They further reported that it was intermittent and there were many days and shifts where residents did not receive their tub baths.

During an interview with PSW #110, they reported that in January the water was cold to lukewarm for a couple weeks, and tub baths couldn't be done on day shifts.

During an interview with PSW #111, they reported that over the past year the water temperature had been fluctuating from hot to lukewarm and wouldn't warm up. They further reported there had been several times where residents haven't had their tub bath twice a week and that after the second or third bath was done, the water became lukewarm.

During an interview with PSW #101, they reported that there were issues with water being lukewarm starting in January 2016, and some days they couldn't do tub baths and would give residents sponge baths. They further confirmed that due to lack of hot water, resident #011 had a sponge bath in January 2016, and resident #012 had a sponge bath in January 2016.

During an interview with PSW #102, they reported that there were three weeks in January where the water was cool, sometimes lukewarm and bed baths had to be done during that time. They further confirmed that due to lack of hot water, residents received bed baths on the following days:

- one day in January 2016: resident #011

- one day in January 2016: resident #013
- one day in January 2016: resident #014
- one day in January 2016: resident #015

During an interview with PSW #117, they reported that the water was cool to lukewarm and due to lack of hot water, residents received bed baths on the following days:

-one day in January 2016: resident #016
-one day in January 2016: resident #007
-one day in January 2016: resident #006
-one day in January 2016: resident #008
-one day in January 2016: resident #010
-one day in January 2016: resident #004
-one day in January 2016: resident #005

During an interview with a family member of resident #010, they reported a time during this winter when the home was having a problem with the boiler and the resident was given a bed bath due to lack of hot water.

During time of inspection, the Inspector found the resident care areas to have hot water.

During an interview with ESM #112, they stated that the home had intermittent hot and cold water temperatures in January and both mixing valves were replaced in March. They further reported that the fluctuating water temperatures affected the resident care areas and they were never without hot water. They further confirmed that there were no records of the Hot Water Temperature Monitoring forms or Daily Maintenance Audit Forms and staff were not following these policies concerning water temperatures.

During an interview the Executive Director (ED) and Director of Care both reported that the home was never without hot water in January and February. [s. 15. (2) (c)]

(577)

2. A review of resident #001's progress notes revealed that in November 2015, the resident's family reported to staff that the resident looked uncomfortable in

their chair and had been leaning forward in their chair the previous day and were concerned that they were in pain. Progress notes dated December 2015, revealed that PT #100 found the resident's special seating cushion to be punctured in one of the cell's. Progress notes dated December 2015, revealed that RN #113 found the replacement seating cushion to be flat, with no pressure downloading while the resident was up in their chair. The progress note further indicated that the resident had further altered skin integrity due to pressure from the flat seating cushion.

During an interview with Physiotherapist (PT) #100, they stated that the resident was transferred to a special chair with a seating cushion in September 2015. They further confirmed that the PSW 's are responsible for filling air into the seating cushions and the flat seating cushion contributed to the cause of the altered skin integrity. [s. 15. (2) (c)]

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicates minimal harm or potential for actual harm and the compliance history which indicates previous non-compliance (NC) issued including a Written Notification (WN) for inspection #2015_246196_0016 on February 12, 2016, and a Written Notification (WN) for inspection #2014_246196_0017 on February 27, 2015. (577) (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2016

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. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure that procedures are developed and implemented to ensure that 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.

The home must ensure that the following monitoring mechanisms are completed and recorded:
1) The Daily Maintenance Audit
2) The Hot Water Temperature Recording daily from different locations within the home
3) The Bath/Shower Water Temperature log's for each home unit, measured and recorded for every resident bath/shower

Grounds / Motifs :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

A complaint was received by the Director in January 2016, reporting that the home had water maintenance issues for a few weeks in January.

A review of the home's policy titled "Daily Maintenance Audit - ESP-B-05", last revised September 2004, indicated that the home will have established and implemented a recording mechanism for maintenance requirements, as follows:

-record all of the following on the "Daily Maintenance Audit Form - ESP-B-05-05", daily for a period of one month: domestic water return temperature, domestic water storage temperature, heating water return temperature, heating water supply temperature;

-the daily recording log will be kept in the boiler room in close proximity to the mixing valves; and

-readings will be done by the Environmental Services Manager or designate Monday to Friday and the Charge Nurse on weekends.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there are no records of the Daily Maintenance Audit Form and staff

were documenting the information on a form "Hot Water Tank Reading", which reads the water temperature at the source. They further confirmed that staff weren't following the policy.

A review of the "Hot Water Tank Reading" forms revealed inconsistent readings or no readings, on the following dates:

-one day in January 2016: no reading
-one week in February 2016: no reading, "reading still not stable, valve to be installed next week"
-six other days in February 2016: no reading
-three days in March 2016: no reading

A review of home's policy titled "Hot Water Temperature Monitoring - ES-B-90", last revised September 2002, indicated that water temperatures within the residence will be maintained according to legislative and/or company standards. Within the policy, listed under 'procedure' the following was indicated:

-record water temperature daily on the "Hot Water Temperature Record - ES-B-90-05";

-run the tap for three to five minutes and take water temperature samples from different locations; and

-temperatures should not fall below 40 degrees Celsius or exceed 49 degrees Celsius, should temperatures fall outside these ranges, the Executive Director or designate must notify both the ESM/Maintenance and nursing, and corrective action must be taken.

During an interview with the Environmental Services Manager (ESM) #112, they reported that there are no records of completed Hot Water Temperature Monitoring forms and staff were not following these policies concerning water temperatures.

A review of the home's policy titled "Bathing and Showering - LTC-H-40", last revised March 2016, indicated that "at a minimum, 3 water temperature checks shall be performed and recorded for each bath/shower, prior to immersing resident into tub or giving shower. One staff member shall be responsible for running the water, performing and recording the required water temperature

checks. Staff were required to document the temperature checks on the "Bath/Shower Temperature Log - LTC-H-40-05".
-Check # 1: check the water temperature while the water is running using the integrated tub thermometer, if available, or a hand-held thermometer;

-Check #2: hold the hand-held thermometer in the water until temperature reading is steady; and

-Check #3: immediately prior to resident entering the water, staff immerses own forearm or holds the inside of their forearm into the water for at least five seconds.

A review of the "Bath/Shower Water Temperature Log - LTC-H-40-05" recorded for each home unit for 2016, indicated inconsistencies in documentation. The following dates indicate when the temperature checks were completed:

Home area #1:
-January 2016: three days
-February 2016: ten days
-March 2016: 12 days, no temperature checks documented under 'Check 2' for 13 baths given

Home area #2:
-January 2016: six days
-February 2016: six days
-March 2016: 16 days

Home area #3:
-no tub temperatures for January-March 2016

Home area #4:
-January 2016: one day
-February 2016: no tub temperature checks
-March 2016: one day

During an interview with ESM #112, they stated that there were no records of the Hot Water Temperature Monitoring forms, Daily Maintenance Audit Forms and staff were not following these policies concerning water temperatures. They further confirmed that there were no other records verifying Bath/Shower Water

Temperature log's for 2016. [s. 90. (2) (k)]

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicates minimal harm or potential for actual harm.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2016

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

Order / Ordre :

The home shall ensure that each resident is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, specifically in regards to all residents on Blue Herron.

Grounds / Motifs :

1. The licensee failed to ensure that each resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the Director in January 2016, reporting that the home did not have consistent hot water for a few weeks in January 2016, and not all residents were receiving tub baths.

A review of the home's policy titled "Bathing and Showering - LTC-H-40", last revised March 2016, indicated that residents will be offered a tub bath or shower at least two times weekly.

During a record review of resident's baths on a home unit, inspector found 40 'sponge baths' recorded for 21 residents, documented the last two weeks of January. A review of residents care plans found that six of those residents preferred tub baths or showers to be given twice a week. 21/32 residents did not have their bathing preference documented in their care plan.

A review of resident #004's care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on three days in January 2016.

A review of resident #005's care plan revealed that showers was their bathing preference. A record review revealed that resident had a sponge bath on two days in January 2016.

A review of resident #006's care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on three days in January 2016.

A review of resident #007's care plan revealed that showers was their bathing preference. A record review revealed that resident had a sponge bath on two days in January 2016.

A review of resident #008's care plan revealed that tub baths was their bathing preference. A record review revealed that resident had a sponge bath on one day in January 2016.

A review of resident #009's care plan revealed that tub baths and showers was their bathing preference. A record review revealed that resident had a sponge bath on one day in January 2016.

A review of resident #010's care plan revealed that a spa bath once a week was their bathing preference. A record review revealed that resident had a sponge bath on one day in January 2016.

During an interview with RPN #108 and PSW #109, they reported that there were issues with lack of hot water beginning in January 2016, and this occurred for over a month. They further reported that the water temperature was not consistently hot and there were many days and shifts where residents didn't get there tub baths.

During an interview with PSW #110, they reported that in January, the water was cold to lukewarm for a couple weeks, and tub baths couldn't be done on day shifts.

During an interview with PSW #111, they reported that over the past year the

water temperature has been fluctuating from hot to lukewarm and wouldn't warm up. They also reported there have been several times where residents did not have their tub bath twice a week and that after the second or third bath was done, the water became lukewarm.

During an interview with PSW #101, they reported that there were issues with water being lukewarm starting in January 2016, and some days they couldn't do tub baths and would give residents sponge baths. They further confirmed that due to lack of hot water, resident #011 had a sponge bath on one day in January 2016 and resident #012 had a sponge bath on two days in January 2016.

During an interview with PSW #102, they reported that there were three weeks in January where the water was cool, sometimes lukewarm and bed baths had to be done during that time. They further confirmed that due to lack of hot water, residents received bed baths on the following days:
-one day in January 2016: resident #011
-one day in January 2016: resident #013
-one day in January 2016: resident #014
-one day in January 2016: resident #015

During an interview with PSW #117, they reported that the water was cool to lukewarm and due to lack of hot water, residents received bed baths on the following days:
-one day in January 2016: resident #016
-one day in January 2016: resident #007
-one day in January 2016: resident #006
-one day in January 2016: resident #017
-one day in January 2016: resident #010
-one day in January 2016: resident #004
-one day in January 2016: resident #005

During an interview with a family member for resident #010, they reported a time during this winter when the home was having a problem with the boiler and resident was given a bed bath due to lack of hot water.

During an interview with ESM #112, they confirmed that the home had intermittent hot and cold water temperatures in January and both mixing valves were replaced in March. Reports this affected resident care areas and they were never without hot water.

During an interview with the DOC they confirmed that it was the expectation of the home that residents receive their bathing preference and further confirmed that those residents received sponge baths. [s. 33. (1)]

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which indicated a pattern, the severity which indicates minimal harm or potential for actual harm. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 14th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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