Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 7, 2018	2018_725522_0001	002429-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the City of St. Thomas
545 Talbot Street ST. THOMAS ON N5P 3V7

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

Valleyview Home
350 Burwell Road ST. THOMAS ON N5P 0A3

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

JULIE LAMPMAN (522), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 5, 6, 7, 8, 9, 12, 13, and 19, 2018.

The following intakes were completed within the Resident Quality Inspection:

Complaint IL-49260-LO/Log # 003121-17 related to alleged resident to resident abuse;
Critical Incident System report #628-000005-17/Log #008461-17 related to a medication incident;
Follow-up Log # 025555-17 related to compliance order #001 from Resident Quality Inspection #2017_660218_0007 related to non-allowable resident charges.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Continuous Quality Improvement Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Food Services Director, the Activation Supervisor, the Volunteer Coordinator, a Pharmacist, a Physician, a Housekeeper, Registered Nurses, Registered Practical Nurses, Personal Support Workers, representatives from Family and Residents' Councils, family members and residents.

The inspectors also toured the home, observed resident care provision, resident and staff interactions, medication administration, medication storage areas, and the general maintenance and cleanliness of the home. Inspectors reviewed residents' clinical records, relevant meeting minutes, internal investigation notes, medication incident reports, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **12 WN(s)**
- **10 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
O.Reg 79/10 s. 245.	CO #001	2017_660218_0007	524

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by

initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) During stage 1 of the Resident Quality Inspection (RQI), an identified resident was noted as having altered skin integrity.

On three occasions during the RQI the resident indicated they were having pain due to the altered skin integrity.

Review of the identified resident's clinical record noted the resident had the area of altered skin integrity for six months.

Review of the resident's most recent quarterly Minimum Data Set (MDS) assessment noted the resident had been experiencing moderate pain due to the area of altered skin integrity.

Upon review of the resident's electronic and hard copy chart there was no documented evidence that a pain assessment was completed for the resident.

The home's Pain Assessment Policy No. RC & S 15-10 stated in part, "A pain assessment, utilizing the clinically appropriate tool will be completed at the following times to correspond with the MDS Assessment as appropriate:
Within the first 7 days following admission.
Quarterly as per the MDS schedule.
With any Significant Change MDS Assessment.
At times other than the MDS Assessment period a full pain assessment is to be completed if the resident has a new diagnosis of a painful condition."

In an interview, the Registered Nurse (RN) and inspector reviewed the identified resident's electronic and hard copy clinical record. The RN confirmed that the resident did not have a pain assessment completed.

The RN stated that the resident should have had a pain assessment completed with a change in status.

B) Review of an identified resident's most recent MDS quarterly assessment indicated the resident had no pain.

Review of the resident’s progress notes completed after the most recent MDS assessment noted the resident was experiencing pain and had been referred to the doctor for pain control and the resident's care plan was revised to reflect pain management.

Review of the resident’s doctor’s orders noted the resident had an order for routine and as needed pain medication.

Review of the resident’s electronic and hard copy chart revealed no documented evidence of a pain assessment for the resident.

In an interview, the Registered Practical Nurse (RPN) reviewed the identified resident's electronic chart and hard copy chart with the inspector and confirmed the absence of a documented pain assessment. The RPN stated the resident should have had a pain assessment due to the resident’s current status and change in pain medication.

C) In an interview, an identified resident stated they experienced frequent pain.

Review of the resident’s MDS Annual Assessment noted that the resident had moderate pain less than daily. The assessment also indicated that the resident frequently complained of pain.

The resident’s quarterly MDS Assessment noted the resident had moderate pain less than daily. The resident’s latest quarterly MDS assessment noted the resident had mild pain less than daily.

Review of the resident’s most recent care plan noted a focus related to pain.

Review of the resident’s doctor’s orders noted the resident had initially been order pain medication as needed which was then changed to daily pain medication.

Review of the identified resident’s electronic and hard copy chart revealed there was no pain assessment completed when the resident was prescribed pain medication daily.

In an interview, the Registered Practical Nurse reviewed the resident's electronic and hard copy chart with the inspector and confirmed the absence a recent documented pain assessment. The RPN stated the resident should have had a pain assessment completed with the change in pain medication.

In an interview, the ADOC stated that all three identified residents should have had a pain assessment completed.

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 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).

Findings/Faits saillants :

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

A) During stage 1 of the Resident Quality Inspection, an identified resident was noted as having altered skin integrity.

On several occasions during the RQI, the resident was observed out of bed and had complained of pain related to the area of altered skin integrity. The resident stated that staff did not assist them with repositioning while they were up throughout the day.

Review of the identified resident's quarterly MDS assessment indicated that the resident had moderate pain less than daily and that in the last seven days the resident had

experienced pain due the area of altered skin integrity.

Review of the resident’s most recent care plan noted interventions for repositioning.

In an interview, the Personal Support Worker (PSW) stated that the resident required assistance with repositioning. The PSW reviewed the resident’s kardex and Point of Care (POC) and could not find any documentation related to repositioning the resident.

In an interview, another PSW stated if there was no documentation related to repositioning in the resident’s kardex or POC then there was no documented direction for repositioning.

The PSW stated that a repositioning schedule should be posted at the resident’s bedside. The PSW and the inspector reviewed the repositioning schedule at the resident’s bedside. The PSW confirmed the schedule did not indicate when to reposition the resident.

Review of the home’s Turning and Repositioning Schedule Policy No. RC & S 08-20 stated, "All resident's dependent on staff for repositioning are to be turned and repositioned by PSW staff every 2 hours (bed or chair) whilst awake. When care needs require an alteration to this practice, a resident specific turning and repositioning schedule will be implemented by the RN/RPN. RN/RPN to assess and implement a resident specific turning schedule and document this on the resident's plan of care. Complete and post "Turning and Repositioning Schedule" at the resident's bedside. Reassess as required."

In an interview, the ADOC stated there should be a specific focus in the plan of care for the identified resident regarding repositioning.

B) Review of doctor's orders for two identified residents noted the residents had orders for routine and as needed narcotic analgesics.

The doctor's orders stated the analgesics were to be given "as needed for no indication" and "for indication not provided."

The identified residents' doctor’s orders were reviewed with the home's physician. The physician acknowledged that the written orders in both resident charts did not include a specific indication for administration of both regularly scheduled narcotics and as needed

narcotics. The physician stated that directions for use should be included on the doctor's orders and this was an area they were working on.

In an interview, the ADOC stated that directions for use of analgesics and narcotics should be provided in the doctor's orders and in the resident's electronic Medication Administration Record. The ADOC stated when the home completed their Medication Safety Self-Assessment for Long Term Care in April 2017, this was identified as an area for improvement.

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. [s. 6. (1) (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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 abuse of a resident by anyone, that the licensee knows of, or that was reported was immediately investigated.

Ontario Regulation 79/10 defines emotional abuse as "Any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Ontario Regulation 79/10 defines physical abuse as "The use of physical force by anyone other than a resident that causes physical injury or pain."

In an interview, during stage 1 of the Resident Quality Inspection, an identified resident stated a specific Personal Support Worker (PSW) was rough with the resident. The resident stated the PSW was not respectful as they were in a hurry when they provided the resident care. The resident stated they had reported their concerns to a staff member but was unable to recall the name of the staff member.

In an interview with the Director of Care (DOC) and Assistant Director of Care (ADOC) they stated there had been previous concerns regarding the specific PSW. The ADOC stated they had spoken to the PSW during their most recent performance appraisal regarding this.

A review of the PSW's most recent performance appraisal (PA) noted no mention of concerns related to their performance. The ADOC reviewed the PA and stated it did not look like they had documented anything, that the ADOC must have just had a conversation with the PSW. When asked by the inspector if the ADOC had documentation regarding the complaints from residents and follow up to the complaints, the stated they did not. The ADOC stated staff had also complained about the PSW and they did not document the concerns rather they spoke with the PSW about the concerns.

A review of a complaint file for the PSW noted the following complaints:

1) On a specific date, a staff member emailed a complaint to the DOC regarding concerns related to the specific PSW. The email did not include the names of residents involved.

In an interview, the inspector asked the DOC if they had spoken with the PSW involved.The DOC stated they did not recall. The DOC stated there was no follow up with the residents involved to determine if there was any effect on the residents. The DOC stated resident's family members were not made aware of the incidents.

2) On a specific date, a complaint was received from a resident's family member regarding the care the specific PSW provided to a resident. The DOC noted on the complaint that the family member did not wish the issue to be addressed with the PSW, nor did the resident, but wanted the DOC to be aware for residents that could not speak up for themselves.

In an interview, the DOC acknowledged that they had not spoken to the PSW regarding the concerns brought forward by the family member.

A note was attached to both complaints which indicated that the PSW's performance appraisal was completed later in the year by the ADOC and both issues were addressed.

3) On a specific date, a written complaint was made by a Dietary Aide (DA) and sent to the Food Services Director (FSD) related to concerns regarding the specific PSW's approach with residents.

An email was sent from the FSD to a Registered Nurse (RN) with the concern from the DA. The RN replied to the FSD and copied the DOC. The RN stated they also had concerns regarding the PSW's approach with residents.

In an interview, the DOC acknowledged she had not spoken with the staff members who had made the complaint. The DOC stated she was pretty sure she had spoken to the PSW involved but she did not document it.

In all three incidents there was no documentation to support that the incidents had been investigated and the concerns had been addressed with the PSW immediately after the DOC became aware of the concerns.

In an interview, the Administrator stated they would expect that there would be immediate follow up with the PSW regarding the complaints.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of

abuse of a resident by anyone, that the licensee knows of, or that was reported was immediately investigated. [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 abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting,

intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Ontario Regulation 79/10 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

In an interview, during stage 1 of the Resident Quality Inspection, an identified resident stated a specific Personal Support Worker (PSW) was rough with the resident. The resident stated the PSW was not respectful as they were in a hurry when they provided the resident care. The resident stated they had reported their concerns to a staff member but was unable to recall the name of the staff member.

In an interview with a Registered Nurse, they stated that residents had indicated that the PSW was rushed and abrupt.

In an interview with the DOC and the ADOC, they stated there had been previous concerns with the PSW.

A review of a complaint file for the PSW noted the following complaints:

1) On a specific date, a staff member emailed a complaint to the DOC regarding concerns related to the specific PSW. The email did not include the names of residents involved.

In an interview, the inspector asked the DOC if they had spoken with the PSW involved.The DOC stated they did not recall. The DOC stated there was no follow up with the residents involved to determine if there was any effect on the residents. The DOC stated resident's family members were not made aware of the incidents.

2) On a specific date, a complaint was received from a resident's family member regarding the care the specific PSW provided to a resident. The DOC noted on the complaint that the family member did not wish the issue to be addressed with the PSW, nor did the resident, but wanted the DOC to be aware for residents that could not speak up for themselves.

In an interview, the DOC acknowledged that they had not spoken to the PSW regarding the concerns brought forward by the family member.

A note was attached to both complaints which indicated that the PSW's performance appraisal was completed later in the year by the ADOC and both issues were addressed.

3) On a specific date, a written complaint was made by a Dietary Aide (DA) and sent to the Food Services Director (FSD) related to concerns regarding the specific PSW's approach with residents.

An email was sent from the FSD to a Registered Nurse (RN) with the concern from the DA. The RN replied to the FSD and copied the DOC. The RN stated they also had concerns regarding the PSW's approach with residents.

In an interview, the Administrator stated they were not aware that the incidents were reported to the Director as they would remember signing off on them. The Administrator stated that regarding the complaint from the family member, it was most likely not reported as the family member did not want to pursue the issue.

In a phone interview, the DOC acknowledged that none of the complaints were reported to the Director. The DOC acknowledged that they had not considered the incidents as abuse and regarding the complaint from the family member, the family member did not want anything done.

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 risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. [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 a person who has 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 risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: 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 her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home, on a specified resident home area (RHA) tub room, one pair of unlabelled nail clippers were observed on the shelf beside the tub.

On another RHA tub room, one pair of unlabelled nail clippers were observed on the shelf beside the tub. In an interview, the PSW stated nail clippers should be labelled. The PSW stated when residents had a bath they take the resident's basket with their name on it out of their cubby in the tub room and used the nail clippers from the resident's basket. The PSW stated sometimes the stickers or names rubbed off and the nail clippers that were left most likely belonged to the resident who had just had a bath.

On another RHA tub room, two pairs of unlabelled nail clippers were observed on the shelf beside the tub. In an interview, the PSW stated most residents had their own nail clippers in their baskets but staff liked to use the large clippers and staff would clean the nail clippers in Dettol after each use.

In an interview, the ADOC stated that all resident personal care items were kept in baskets labelled with the resident's name in cubbies in each tub room. The ADOC stated each resident had their own nail clippers. The ADOC stated the nail clippers would not necessarily be labelled as the basket was labelled with the resident's name and the nail clippers should be placed back in the basket after the resident's bath.

The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of 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 her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

According to a identified resident's admission Minimum Data Set (MDS) assessment the resident was noted to be incontinent of bladder . The resident was noted to be frequently incontinent of bladder according to the most recent MDS quarterly assessments. This triggered the urinary continence resident assessment protocols (RAP).

There was no documented evidence of a continence assessment for the identified resident. This was verified by the Assistant Director of Care (ADOC) and the Registered Nurse (RN) after review of the clinical records. The RN said that a continence assessment would be completed at admission and with a change in continence status.

The home's policy titled "Continence Care and Bowel Management Program", No. RC & S 07-1 stated under procedure that “Following completion of the Three Day Bladder and Bowel Function Record, the RN/RPN will complete the comprehensive Bladder and Bowel Continence Assessment, utilizing data obtained from the observational record, resident/family interview, progress notes, PSW flow sheet charting, RAI-MDS 2.0 assessment, triggered Urinary Continence RAP and Nursing Restorative Programs as applicable."

During an interview with the ADOC, they acknowledged that there was no documented evidence of a completed clinically appropriate assessment tool for incontinence in the electronic or hard copy files for the identified resident and there should have been one completed.

The licensee has failed to ensure that, each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (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 who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

During an interview with the Residents' Council representative, when asked if the meal and snack times were reviewed by the Residents' Council, they told the inspector that everything was written down in the meeting minutes.

A review of the Residents' Council meeting minutes and interview with the Food Services Director indicated there was no evidence to support that meal and snack times were reviewed by Residents' Council.

The Food Services Director acknowledged that the dining and snack service had not included a review of the meal and snack times by the Residents' Council and they would do so at the next meeting.

The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council. [s. 73. (1) 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 dining and snack service includes a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually related to the following:
• The home's policy to promote zero tolerance of abuse and neglect of residents;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections.

In an interview, a housekeeping staff member stated they were unaware of the requirement for mandatory reporting of abuse to the Director and they were not knowledgeable about whistle-blowing protection when questioned.

Review of the home’s 2017 training records related to resident abuse and neglect showed that 15 out of 23 (65 percent) dietary staff did not receive training on resident abuse and neglect.

In an interview, the Food Services Director stated that new staff received training on abuse and neglect during their orientation in 2017, but that regular staff did not receive training on abuse and neglect and they should have.

In an interview, the Administrator confirmed that dietary staff should have received annual training on abuse and neglect.

The licensee has failed to ensure that all staff had received retraining annually related to the following:
• The home's policy to promote zero tolerance of abuse and neglect of residents;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections. [s. 76. (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 all staff have received retraining annually related to the following:
• The home's policy to promote zero tolerance of abuse and neglect of residents;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During the initial tour of the home, on March 5, 2018 at 0950 hours, on Chesapeake Way resident home area (RHA) the door to the soiled utility room was found unlocked. Inside the room a cabinet door was found unlocked with six one litre bottles of Dettol antiseptic which had a poison warning on the label, a container of Rescue Sporicidal wipes and Gojo antibacterial hand wash inside. The bed pan sanitizer was observed to have a key in the lower door, which provided access to the cleaning chemicals inside the machine. A PSW confirmed the cabinets were unlocked and the keys were left in the sanitizer. The PSW stated that the door to the soiled utility room was not locked but the cabinets should be locked and the sanitizer should be locked. The PSW locked the cabinet door and stated they would speak with their supervisor regarding the sanitizer as the key was stuck in the lock.

On March 5, 2018, at 1010 hours, on Wabash Line RHA the door to the soiled utility room was observed unlocked. Inside the room a cabinet door was found unlocked with six one litre bottles of Dettol antiseptic, a bottle labelled diluted Dettol and Swish aromx 60 super

strength foul odour eliminator inside. Another cabinet door was found unlocked with a bottle labelled diluted Dettol inside. The sanitizer machine door was unlocked and slightly ajar with the key in it which provided access to the cleaning chemicals inside. A PSW confirmed the cabinet doors were unlocked and the sanitizer door was slightly ajar with the key in it. The PSW stated soiled utility rooms were not locked but the cabinets should be locked after use as all staff members had keys. The PSW locked the cabinet doors and locked the sanitizer door and put the key away.

On March 6, 2018, at 1005 hours, the door to the soiled utility room on Wabash Line RHA was observed unlocked. Inside the room a cabinet door was found unlocked with six one litre bottles of Dettol antiseptic. Two residents were observed sitting outside the door by the nurses station. A PSW confirmed the cabinet door was unlocked and locked the cabinet.

On March 7, 2018, at 1044 hours, the door to the soiled utility room on Cheapeake Way RHA was observed unlocked. Inside the room a cabinet door was found unlocked with six one litre bottles of Dettol antiseptic, a container of Rescue Sporicidal wipes, Gojo antibacterial hand wash and Swish Kling washroom lotion cleanser. A PSW entered the room and confirmed the cabinet was unlocked. The PSW stated they left the cabinet open as they had just given a resident a bath. The PSW locked the cabinet door.

In an interview on March 7, 2018, the ADOC stated the door to the soiled utility room on CN was locked but on all other RHAs the soiled utility room was unlocked and the cabinets with chemicals were to be locked at all times. ADOC stated that staff had their own keys and should lock the cabinets after use. The ADOC stated the keys should never be left in the sanitizer doors. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home. The CIS report stated that a resident was given the wrong medication which resulted in the resident needing medical attention.

A review of the CIS report indicated that the Registered Practical Nurse (RPN) gave the resident the bedtime medications belonging to another resident.

In a phone interview, the RPN stated they were asked to give meds on a home area they were not familiar with. During the medication pass they were interrupted by another staff member. The RPN went in to give the resident their medication and asked the resident their name, the resident nodded and the RPN gave the resident the medication. The RPN stated when they went to sign off the medication on the electronic Medication Administration Record they realized they had gone into the wrong room and administered the medication to the wrong resident. The RPN stated they immediately went to the Registered Nurse (RN) and told them of the error.

In a phone interview, the RN stated they had asked for assistance with the medication pass from the RPN who worked on another home area. The RN stated this was normal practice. The RN stated that the RPN made them aware of the med error and the RN assessed the resident and contacted the doctor who was already in the home at that time. The RN stated there were no adverse effects to the resident as a result of the error.

The licensee has failed to ensure that no drug was administered to a resident in the

home unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017. In total there were eight medication incidents during this time period.

A) In one incident, a resident was not administered their medication as ordered. The Medication Incident/Near Miss report indicated that the Registered Practical Nurse (RPN) stated the unit was busy and they had forgotten to give the medication. There were no adverse effects to the resident.

B) In a second incident, resident was not administered their medication as ordered. The Medication Incident/Near Miss report indicated that the RPN became distracted by another resident and forgot to give the medication. There were no adverse effects to the resident.

C) In a third incident, a resident was not administered their medication as ordered. The Medication Incident/Near Miss report indicated that on that day the internet service was out in the home and the electronic Medication Administration Record (eMAR) was not available. The RPN who administered the medications did not follow the resident's paper MAR. There were no adverse effects to the resident.

In an interview, the ADOC reviewed the medication incidents and indicated that the medications were not administered as ordered by the physician.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident or the resident's substitute decision-maker, the Medical Director and the pharmacy service provider.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017. In total there were eight medication incidents during this time period.

A) In one incident, a resident was not administered their medication as ordered. The Medication Incident/Near Miss report indicated that the registered practical nurse became distracted by another resident and forgot to give the medication. The report indicated that the resident's substitute decision-maker (SDM) was not notified.

During a phone interview, the SDM for the resident stated they were not called and informed of the medication error.

In an interview, the DOC indicated the resident's SDM should have been notified of the medication incident.

B) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home. The CIS report stated that a resident was given the wrong medication which resulted in the resident needing medical attention.

A review of the CIS report indicated that the RPN gave a resident the bedtime medications belonging to another resident.

In an interview, the ADOC stated there was no Medication Incident/Near Miss report completed for the incident and the incident was documented under risk management.

Review of the risk management report for the medication incident noted that the pharmacy service provider and the Medical Director were not notified of the incident.

In an interview, the Physician confirmed they were the Medical Director for the home. The Physician stated they were not made aware of the medication incident related to the resident.

In an interview, the ADOC stated that the incident should have been documented on the Medication Incident/Near Miss report. The ADOC stated the risk management report would not have been faxed to pharmacy and they could not confirm if pharmacy was made aware of the incident. The ADOC stated the Medical Director should have been made aware of the medication incident.

In a phone interview, the Pharmacist stated they were not aware of the medication incident related to the resident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident or the resident's substitute decision-maker, the Medical Director and the pharmacy service provider. [s. 135. (1) (b)]

2. The licensee has failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b).

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home. The CIS report stated that a resident was given the wrong medication which resulted in the resident needing medical attention.

A review of the CIS report indicated that the RPN gave the resident the bedtime medications belonging to another resident.

In an interview, the ADOC stated there was no Medication Incident/Near Miss report completed for the incident and the incident was documented under risk management.

A review of the risk management report noted there was no documentation related to identifying factors (root cause) contributing to the incident or corrective actions to prevent similar occurrences in the future.

In an interview, the ADOC stated that the incident should have been documented on the Medication Incident/Near Miss report. The ADOC stated there was no analysis completed for this incident.

In a phone interview, the Pharmacist stated they were not aware of the medication incident related to the resident. The Pharmacist stated the incident was not reviewed at the quarterly medication review meeting on May 4, 2017, and the incident was not analyzed.

A review of the CIS report indicated that the RPN would complete specific training due to

the medication incident.

In an interview, the ADOC stated they had a discussion with the RPN, but could not provide documentation related to discussion or education/retraining that the RPN received.

The licensee has failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker, the Medical Director and the pharmacy service provider; and to ensure that:
a) All medication incidents, are documented, reviewed and analyzed;
b) Corrective action is taken as necessary; and
c) A written record is kept of everything required under clauses a) and b), to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of each documented complaint record reviewed and of the improvements made in response.

During stage 1 of the Resident Quality Inspection, a specific resident had expressed concerns related to the care provided by a specific PSW.

Review of the PSW’s file noted a complaint from a family member and three complaints from staff members against the PSW related to resident care and the PSW's approach with residents.

Review of the complaints revealed the complaints were not fully investigated, follow up was not done with residents involved, family was not notified and the PSW was not followed up with immediately.

A review of the Resident/Family Concern Complaint binder noted there were six complaints from February 28, 2017 to January 2, 2018.

Review of the home's Review of Complaints Policy No. ADMIN 2-60 (no date) stated in part,
“Quarterly all documented verbal and written complaints will be reviewed at the Management Meeting to analyze for trends.
The results of the review and analysis will be taken into account to determine what improvements can be made in the home.
A written record will be kept of the quarterly reviews and improvements made in response.”

In a phone interview, the Administrator confirmed for all complaints that the Administrator and the DOC verbally reviewed them quarterly but there was no documented review and analysis of complaints that they received.

The licensee has failed to ensure that a written record was kept of each documented complaint record reviewed and of the improvements made in response. [s. 101. (3) (c)]

Issued on this 25th day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522), INA REYNOLDS (524)
Inspection No. / No de l'inspection :	2018_725522_0001
Log No. / No de registre :	002429-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 7, 2018
Licensee / Titulaire de permis :	The Corporation of the City of St. Thomas 545 Talbot Street, ST. THOMAS, ON, N5P-3V7
LTC Home / Foyer de SLD :	Valleyview Home 350 Burwell Road, ST. THOMAS, ON, N5P-0A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Carroll

To The Corporation of the City of St. Thomas, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 52 (2) of O. Reg 79/10.

Specifically the licensee must:
a) Ensure identified residents receive pain assessments.
b) Ensure all residents who have pain that is not relieved by initial interventions, receive
a pain assessment.

Grounds / Motifs :

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

During stage 1 of the Resident Quality Inspection (RQI), an identified resident was noted as having altered skin integrity.

On three occasions during the RQI the resident indicated they were having pain due to the altered skin integrity.

Review of the identified resident's clinical record noted the resident had the area of altered skin integrity for six months.

Review of the resident's most recent quarterly Minimum Data Set (MDS) assessment noted the resident had been experiencing moderate pain due to the area of altered skin integrity.

Upon review of the resident's electronic and hard copy chart there was no documented evidence that a pain assessment was completed for the resident.

The home's Pain Assessment Policy No. RC & S 15-10 stated in part, "A pain assessment, utilizing the clinically appropriate tool will be completed at the following times to correspond with the MDS Assessment as appropriate:
Within the first 7 days following admission.
Quarterly as per the MDS schedule.
With any Significant Change MDS Assessment.
At times other than the MDS Assessment period a full pain assessment is to be completed if the resident has a new diagnosis of a painful condition."

In an interview, the Registered Nurse (RN) and inspector reviewed the identified resident's electronic and hard copy clinical record. The RN confirmed that the resident did not have a pain assessment completed.

The RN stated that the resident should have had a pain assessment completed with a change in status. (522)

2. In an interview, an identified resident stated they experienced frequent pain.

Review of the resident's MDS Annual Assessment noted that the resident had moderate pain less than daily. The assessment also indicated that the resident frequently complained of pain.

The resident's quarterly MDS Assessment noted the resident had moderate pain less than daily. The resident's latest quarterly MDS assessment noted the resident had mild pain less than daily.

Review of the resident's most recent care plan noted a focus related to pain.

Review of the resident's doctor's orders noted the resident had initially been order pain medication as needed which was then changed to daily pain medication.

Review of the identified resident's electronic and hard copy chart revealed there was no pain assessment completed when the resident was prescribed pain medication daily.

In an interview, the Registered Practical Nurse reviewed the resident's electronic and hard copy chart with the inspector and confirmed the absence a recent documented pain assessment. The RPN stated the resident should have had a pain assessment completed with the change in pain medication. (522)

3. Review of an identified resident's most recent MDS quarterly assessment indicated the resident had no pain.

Review of the resident's progress notes completed after the most recent MDS assessment noted the resident was experiencing pain and had been referred to the doctor for pain control and the resident's care plan was revised to reflect pain management.

Review of the resident's doctor's orders noted the resident had an order for routine and as needed pain medication.

Review of the resident's electronic and hard copy chart revealed no documented evidence of a pain assessment for the resident.

In an interview, the Registered Practical Nurse (RPN) reviewed the identified resident's electronic chart and hard copy chart with the inspector and confirmed the absence of a documented pain assessment. The RPN stated the resident should have had a pain assessment due to the resident's current status and change in pain medication.

In an interview, the ADOC stated that all three identified residents should have had a pain assessment completed.

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as three out of three residents did not have a pain assessment. The home had a level 2 compliance history as the home had one or more unrelated noncompliance in the last three years.

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 07, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 7th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Julie Lampman

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