Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 16, 2016;	2015_448155_0020 (A1)	019819-15	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

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

SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extension for CO #002 from March 31, 2016 to May 2, 2016.

Issued on this 16 day of March 2016 (A1)

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

Original report signed by the inspector.

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

SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 18, 19, 20, 21, 24, 25, 26, 28, September 1, 2, 3, and 4, 2015.

The following Critical Incident inspections were conducted concurrently during this inspection:

Log # 019150-15/ CI 2603-000019-15

Log # 019692-15/ CI 2603-000020-15

Log # 020938-15/ CI 2603-000022-15

Log # 021464-15/ CI 2603-000023-15

A Follow-up inspection log # 008332-15 was conducted during this inspection.

An on-site inquiry for log 018190-15 / CI 2603-000018-15 was conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Administrative Assistant, Medical Director, Regional Manager, Nurse Consultant, Food Service Supervisor, Resident Care Coordinator, Environmental Services Supervisor, Physiotherapist, Registered Nurse-RAI Coordinator, Nurse Clerk, Restorative Care Aide, Housekeeper, two Registered Nurses (RN), 5 Registered Practical Nurses (RPN), ten Personal Support Workers (PSW), Resident Council representative, Residents and

Families.

The inspector(s) also conducted a tour of all resident areas and common areas; observed residents and care provided to them; observed meal service, medication pass, medication storage areas; reviewed health care records and plans of care for identified residents; reviewed policies and procedures of the home, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

10 WN(s)
5 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 23. (1)	CO #008	2014_202165_0029	568
O.Reg 79/10 s. 50. (2)	CO #001	2015_226192_0028	155
O.Reg 79/10 s. 53. (4)	CO #003	2014_202165_0029	532
O.Reg 79/10 s. 71. (3)	CO #004	2014_202165_0029	614

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. 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 instituted or otherwise put in place was complied with.

The home's policy CODE CARE, stated that when a resident fell, the Safety Plan Intervention form was to be reviewed and updated during the post fall huddle. Staff interview revealed that resident #017 fell. A review of the Safety Plan Intervention form for resident #017 revealed that it was not reviewed and updated after the fall. This was confirmed by both the Nurse Consultant and the Director of Care. The home failed to comply with the policy in place. [s. 8. (1) (a),s. 8. (1) (b)]

2. The pain assessment policy titled "Pain Assessment" dated as effective April 2010 and review date May 2015, stated that the Caressant Care Pain Assessment tool on Point Click Care would be utilized when a new pain medication was initiated , a resident exhibits behaviour that my herald the onset of pain, a resident complains of pain of 4 or greater, a resident exhibited distress related behaviours or facial grimace, a resident/family/staff/volunteers indicated pain was present.

Review of the Resident Assessment Instrument (RAI) Minimum Data System (MDS) Assessment indicated that resident #051 was coded as a two- daily pain that was at times horrible or excruciating.

Record review revealed that the resident indicated they had pain.

During an interview, the Resident Care Coordinator reported that scoring a two under J2 section of the RAI MDS assessment would require the completion of the Caressant Care Pain Assessment tool on Point Click Care. They confirmed that no pain assessment was completed for the resident following the RAI MDS assessment and the policy was not complied with.

b) The Pain Assessment policy also indicated that when a new pain medication was initiated a Caressant Care Pain Assessment Tool on Point Click Care would be completed.

Record review revealed that resident #004 had pain. An interview with the resident confirmed they had pain. Resident #004 scored their present level of pain as more than 4 on the pain scale.

Review of the medication administration record for resident #004 indicated that a new pain medication was initiated. Record review revealed that a Caressant Care Pain

Assessment Tool on Point Click Care had not been completed for resident #004.

The Director of Care confirmed that a pain assessment was to be completed using the Caressant Care Pain Assessment Tool on Point Click Care immediately when a new pain medication was introduced. The Director of Care confirmed it was not done and the pain policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the responsive behaviour management policy was complied with.

Record review revealed that resident #091 had behaviours towards others.

The Resident Behaviour Management Policy effective September 2014 with a review date of May 2015 stated that:
" 1. If a resident is exhibiting a behaviour that is identified by staff to be disruptive or potentially injurious to the resident or others, a responsive behaviour tracking record will be initiated and completed over 72 hours. At the end of 72 hours the flow sheet will be given to the charge nurse to be assessed.
4. The multidisciplinary team will also complete the responsive Behaviour Checklist for potential triggers.
6. If the behaviour continues, despite the use of interventions, the resident will be referred to the Psychogeriatric Consultant for further review and possible recommendations."

Record review of resident #091 revealed that there was no responsive behaviour tracking record and no responsive behaviour checklist for potential triggers completed for this resident. When resident #091's behaviours continued there was no referral to the Psychogeriatric Consultant for further review and possible recommendations.

The Behaviour Support RPN reported that they were not aware of the policy as they were new to the Behaviour Support program at the home. The Behaviour Support RPN confirmed that there was no tracking record or checklist for triggers completed. They acknowledged there was no referral made to the Psychogeriatric Consultant. The Behaviour Support RPN confirmed that the Resident Behaviour Management policy was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The central and north medication carts were observed to be unclean. The medication carts were noted to have spilled liquids and a build up of black dirt/debris on the rubber bumper around the perimeter of the cart. The central medication cart was also noted to have a pink liquid spilled down the back of the cart. The medication crusher on each medication cart were observed to have a build up of a black dirt/debris on them.

Observation further revealed that treatment carts on both home areas were also unclean and untidy.

The above observations were confirmed with the Registered Practical Nurse working in the central medication room and the Registered Nurse confirmed the observations in the north medication room.

Record review of the medication management system program evaluation dated December 2014 revealed that it was identified that the medication rooms were not kept tidy and clean and this was noted as an area of improvement.

During an interview with the Registered Practical Nurse they stated they were not sure if there was a cleaning schedule for the medication cart but acknowledged that the cart should be cleaned after each medication pass. The Registered Practical Nurse further stated that the pill crusher had been kept clean but the dirt was built in. The Registered Practical Nurse then wiped the pill crusher with a wet wipe and it turned grey-black as it removed dirt from the crusher.

The Director of Care confirmed that they had also observed the medication carts to be unclean and untidy and reported that they had issued a memo on July 16, 2015 to the registered staff to ensure the medication carts and the treatment carts were kept clean after the medication pass. [s. 15. (2) (a)]

2. During the initial tour of the home and throughout this inspection the following was observed.
a) Upon entry to the home and the stair way to the second floor, spider webs were noted between the stair banisters, on the lighting and walls. The window and the screen at the top of the stair way was dirty.
b) The flooring and baseboards in the hallways and in 23 resident rooms were noted to have a build up of black dirt and debris notably around the edges.
c) The window and screen in the central activity room and in an identified resident room were noted to be dirty.
d) The fan/skylight in the hallway between room 213 and 215 was noted to have dirt and dust hanging down from the vents and boards.
e) The ceiling tiles in the hallway by rooms 208 and 209 had dust hanging from them. The ceiling vents outside room 212 and 224 were dusty.
f) The floor in the north tub room under the black shelf had a build up of dust.
g) Privacy curtains were soiled in the central and north tub rooms and in six identified resident rooms. Interview with the Housekeeper revealed that privacy curtains were

only washed when a resident room became vacant. Review of the home's Cleaning Guidelines policy indicated that removal and laundering of privacy curtains was done semi-annually or as per the schedule. The Administrator confirmed that privacy curtains were only being laundered when a resident room became vacant.

During a tour of the home with the Environmental Services Supervisor they confirmed the above observations and acknowledged that the home and furnishings were not kept clean and sanitary. [s. 15. (2) (a)]

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

During the initial tour of the home and throughout this inspection the following was observed.

a) The flooring in the elevator was noted to have some cracked and chipped tiles.
b) The central activity room had flooring tiles missing under the new heater.
c) Dry wall damage was noted in the hallway between rooms 208, 210 and 212; central tub room; clean utility room between room 228-230; the north tub room; and in four identified resident rooms/bathrooms.
d) The half wall in the shower area of the central tub room had cracked and missing tiles.
e) Baseboards were missing in two identified resident rooms.
f) Baseboards were coming off in six identified resident rooms/bathrooms.
g) Wall protect was peeling off the walls in three identified resident rooms.
h) Tile flooring was cracked/missing in three identified resident rooms/bathrooms.
i) Corner protect was broken on the door to the small dining room and metal edges were exposed.
j) Paint was chipped on the bathroom doors and/or frames to six identified resident rooms.
k) The flooring at the base of the toilets were noted to be brown and there was no caulking to seal the flooring. This was noted in 11 identified bathrooms.

During a tour of the home with the Environmental Services Supervisor they acknowledged and confirmed that the home needed many repairs done and that the home and furnishings were not maintained in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right not to be neglected by the licensee and staff was respected.

Critical Incident # 2603-000022-15 reported that resident #092 requested assistance from a Personal Support Worker (PSW) however the PSW did not assist resident #092 nor did they notify another staff member despite the requests.

Record review and staff interviews revealed that resident #092 needed assistance. Staff indicated that resident #092 asked for assistance. The plan of care indicated the resident was able to verbalize when they required assistance.

Investigation notes for the critical incident indicated that when the accused PSW was interviewed, they confirmed that they had ignored resident #092. The staff member indicated that they had already assisted the resident earlier in the morning.

An interview with resident #092 conducted by the home following the incident revealed that the resident was upset following the incident.

The Director of Nursing confirmed that resident #092 was neglected and their rights were not respected. [s. 3. (1) 3.]

2. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

During observation of the medication pass resident #053 was observed sitting in the dining room with other residents waiting for the meal. The registered staff approached resident #053 and performed a test. Record review and plan of care for resident #053 indicated that medication was to be administered in the resident's room.

Resident #054 was observed sitting in the dining room waiting for the meal. The registered staff approached resident #054 and administered their medication to them in front of the other residents. Record review and plan of care for resident #054 did not indicate that this medication was to be administered inside the dining room.

The Director of Care confirmed that the resident's privacy in treatment and in caring for his or her personal needs was not promoted or respected. [s. 3. (1) 8.]

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 rights of residents are fully respected and promoted:
every resident has the right not to be neglected by the licensee or staff, and every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Review of resident #030's record indicated that the resident had identified behaviours which was confirmed by the PRN Behaviour Lead. The home identified specific interventions to manage the resident's behaviour. Review of the plan of care did not identify the specific interventions identified by the home. The Director of Care confirmed that the plan of care should have included these interventions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident's needs and preferences.

A review of resident #030's six week post admission care conference notes identified some preferences. A review of the resident's plan of care revealed that these preferences were not included. The Resident Care Coordinator confirmed that it was the homes expectations that resident preferences were included in the plan of care and they were not included for resident #030. [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 was no longer necessary.

The Minimum Data Set (MDS) assessment indicated that resident #092 required the total assistance of two staff for transfers and extensive assistance with two staff for toileting.

Staff interviews with two Personal Support Workers revealed that resident #092's condition had declined and resident #092 now required a mechanical lift for transfers and toileting.

Review of the toileting plan of care for resident #092 indicated that the goal would be to maintain the resident's ability to toilet self safely and appropriately for the next 3 months. Interventions included constant supervision and to provide help when needed. Extensive assistance whereby the resident performed part of the activity over 7 days, and required weight bearing help, or full staff performance 3 or more times in 7 days, but not everyday.

The Director of Nursing confirmed that resident #092's condition declined over the previous quarter and the plan of care had not been revised to reflect the change in care needs. [s. 6. (10) (b)]

4. Resident #030 had a fall. Review of the Safety plan-Post Fall investigation indicated a specific action plan for resident #030. Record review revealed that the care plan had not been updated to include this information.
The plan also indicated that a fall risk assessment tool had been completed for resident #030. The Director of Care confirmed that the care plan was not updated and that a fall risk assessment tool had not been completed after the fall for resident #030. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

Record review revealed that resident #009 had several falls over a two month period.

The home's policy entitled Code Care: Come Assess, React, Evaluate with a review date of May 2015 stated the safety plan intervention sheet was to be reviewed and updated during the huddle. Staff were to review what strategies were tried and what other interventions the group thought could be implemented to prevent future falls.

The Director of Care confirmed that the safety plan interventions were to be used and the suggested interventions were to be tried and evaluated after every fall during a huddle.

Record review and the safety plan review for resident #009 indicated that interventions were reviewed in 2014 and some were deemed ineffective. One intervention was reviewed however, the safety plan sheet was not updated and no new interventions were documented as tried and evaluated after several falls.

The Resident Care Coordinator and the Director of Care confirmed that the resident was reassessed and the plan of care was being revised, however, different approaches were not considered as per the safety plan sheet and the individualized intervention was not tried again with the revision of the plan of care. [s. 6. (11) (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 clear directions to staff and others who provide direct care to the resident; 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; that the resident is assessed 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; and when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was

recorded in respect of every drug that was ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where a controlled substance is destroyed, including documentation as per section 136(4).

The emergency drug record book that was kept in the central medication room was reviewed. It was noted that the date the drug was received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home was not completed in the drug record book.

Further review of the drug record book revealed that the date the drug was received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home was not completed for medications that were delivered to the home on June 3, 7, 9, 18, 23, 30, July 2, 6, 23, 27, and August 1, 4, 11, 13, 14, 20, 21, and 22, 2015.

A review of the audit reports dated January 9, 2015 and August 24, 2015 revealed that it was identified that the emergency drug record book was consistently not being signed in as received. The report from January 2015 was presented at the Professional Advisory committee (PAC) meeting and it was identified that both the Central and North medication drug record book failed to have all of the medications signed in as received.

The drug record book policy 4-1 stated that the drug record book must be maintained and kept in the home for at least two years and ensure the following information was recorded upon receiving a medication- quantity of the prescription, signature/initial of person receiving order, and date the order was received.
The Registered Nurse and the Registered Practical Nurse both acknowledged that medication was not being signed for in the drug record book when they were received.

The Director of Care confirmed that the drug record book was not maintained upon

ordering and receiving of the medications. The date the drug was received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home was not recorded. [s. 133.]

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 drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O.Reg 79/10, s.133., to be implemented voluntarily.

WN #6: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

Record review revealed that there were medication incidents documented on the following dates: March 4, 21, April 2, 3, May 26, June 2, and July 30, 2015.

Record review of the Professional Advisory Committee meeting (PAC) minutes revealed that the medication incidents and adverse drug reactions were not reviewed quarterly at the meeting.

In an interview the Administrator and the Director of Care confirmed that the medication incident reports were not being reviewed quarterly as they were not being documented or reported by the registered nursing staff. The Director of Care reported that a system was implemented where medication incidents were to be reported to the pharmacy via phone and the pharmacy head office was to analyze the data, however, this process had not been followed. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #7: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #024 was admitted to hospital and had altered skin integrity. Record review revealed that when resident #024 returned from hospital there was no skin assessment done. The Resident Care Coordinator confirmed that there was no skin assessment done by a member of the registered nursing staff when resident #024 returned from hospital and the expectation was that a skin assessment was to be completed for all residents on return from hospital. [s. 50. (2) (a) (ii)]

WN #8: 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 were kept inaccessible to residents at all times.

During a tour of the home with the Environmental Services Supervisor the door to the central soiled utility room was opened without using the code to unlock the door. It was noted that the central soiled utility room contained a spray bottle of Diversey-One Step disinfectant and two bottles of Diversey-Neutral Cleaner. The Environmental Services Supervisor confirmed that the door was to be locked. The Environmental Services Supervisor was not aware that the coded lock was not functioning properly. [s. 91.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart,
i. that were used exclusively for drugs and drug-related supplies,
ii. that were secure and locked,
iii. that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
iv. that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).
Note: This subsection does not apply with respect to drugs that a resident was permitted to keep on his or her person or in his or her room in accordance with subsection 131 (7).

Observations of the central and north medication rooms revealed the following expired drugs: Viscopaste expired July 2015, and Uremol 20 urea 20%, expired March 2013.

The above expired drugs were confirmed by both the Registered Nurse and the Registered Practical Nurse. The licensee failed to ensure that drugs were stored as per manufacturer's instructions. [s. 129. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a medication pass it was observed that the Registered Practical Nurse administered an analgesic to resident #002 who had a fever. The Registered Practical Nurse was observed entering and leaving the room of resident #002 without washing their hands. The Registered Practical Nurse continued with the medication pass without any hand hygiene between residents.

The Registered Practical Nurse was observed donning gloves and doing testing on resident #053. The registered staff member was not observed washing their hands before or after completing the testing. They removed their gloves and continued with the medication administration.

The registered staff was observed again putting gloves on and administering medication to resident #054. The registered staff member was not observed washing their hands before or after the medication administration. They removed their gloves and continued with the medication pass.

The Registered Practical Nurse confirmed the observations and stated that they were to wash hands before and after administering medication and/or completing any treatments between residents. They acknowledged that they failed to participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Issued on this 16 day of March 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHARON PERRY (155) - (A1)

Inspection No. / No de l'inspection : 2015_448155_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 019819-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Mar 16, 2016;(A1)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST, FERGUS, ON, N1M-2Y7

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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : CATHY COOK

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_226192_0028, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg 79/10, s.8. (1).(b).

The plan must include what immediate and long term actions will be undertaken to ensure that the home's Pain Assessment Policy for resident #004, #051 and all other residents is complied with. The plan must also include who will be responsible to correct the areas of non-compliance and the dates for completion.

Please submit the plan, in writing quoting log number 019819-15, to Sharon Perry, Long Term Care Homes Inspector -Nursing, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, by email, at Sharon.Perry@Ontario.ca by November 27, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

This has been previously issued as a compliance order #001 on November 24, 2014 during inspection 2014_202165_0029 and as a compliance order #002 on May 8, 2015 during inspection 2014_226192_0028.

The pain assessment policy titled "Pain Assessment" dated as effective April 2010 and a review date of May 2015, stated that the Caressant Care Pain Assessment tool on Point Click Care would be utilized when a new pain medication was initiated , a resident exhibited behaviour that my herald the onset of pain, a resident complained of pain of 4 greater, a resident exhibited distress related behaviours or facial grimace, a resident/family/staff/volunteers indicated pain was present.

Review of the Resident Assessment Instrument (RAI) Minimum Data System (MDS) Assessment indicated that Resident #051 was coded as a two- daily pain that was at times horrible or excruciating.

Record review further stated that the resident indicated they had pain.

During an interview the Resident Care Coordinator reported that scoring a two under J2 section of the RAI MDS assessment would require the completion of the Caressant Care Pain Assessment tool on Point Click Care. They confirmed that no pain assessment was completed for resident #051 following the RAI MDS assessment and the policy was not complied with.

The Pain Assessment policy also indicated that when a new pain medication was initiated that a Caressant Care Pain Assessment Tool on Point Click Care would be completed.

Record review revealed that resident #004 had pain. An interview the resident confirmed they had pain. Resident #004 scored their present level of pain as more than 4 on the pain scale.

Review of the medication administration record for resident #004 indicated that a new pain medication was initiated. Record review revealed that a Caressant Care Pain Assessment Tool on Point Click Care had not been completed for resident #004.

The Director of Care confirmed that a pain assessment was to be completed using the Caressant Care Pain Assessment Tool on Point Click Care immediately when a new pain medication was introduced. The Director of Care confirmed it was not done and the pain policy was not complied with. (532)

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

Dec 29, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s.15.(2)(a).

The plan must include what immediate and long term actions will be undertaken to ensure that the home, furnishings and equipment are kept clean and sanitary. The plan must also include who will be responsible to correct the areas of non-compliance and the dates for completion.

Please submit the plan, in writing quoting log number 019819-15, to Sharon Perry, Long Term Care Homes Inspector - Nursing, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, by email, at Sharon.Perry@Ontario.ca by November 27, 2015.

Grounds / Motifs :

1. This has been previously issued as a written notification and voluntary plan of correction on November 24, 2014 during inspection 2014_202165_0029.

During the initial tour of the home and throughout this inspection the following was observed.
a) Upon entry to the home and the stair way to the second floor, spider webs were noted between the stair banisters, on the lighting and walls. The window and the screen at the top of the stair way was dirty.
b) The flooring and baseboards in the hallways and in 23 resident rooms were noted to have a build up of black dirt and debris notably around the edges.
c) The window and screen in the central activity room and an identified resident were noted to be dirty.
d) The fan/skylight in the hallway between room 213 and 215 was noted to have dirt and dust hanging down from the vents and boards.
e) The ceiling tiles in the hallway by rooms 208 and 209 had dust hanging from them. The ceiling vents outside room 212 and 224 were dusty.
f) The floor in the north tub room under the black shelf had a build up of dust.
g) Privacy curtains were soiled in the central and north tub rooms and in six identified resident rooms.
Interview with the Housekeeper revealed that privacy curtains were only washed when a resident room became vacant. Review of the home's Cleaning Guidelines policy indicated that removal and laundering of privacy curtains was done semi-annually or as per the schedule. The Administrator confirmed that privacy cutrains were only being laundered when a resident room became vacant.

During a tour of the home with the Environmental Services Supervisor they confirmed the above observations and acknowledged that the home and furnishing were not kept clean and sanitary. (155)

2. The central and north medication carts were observed to be unclean. The medication carts were noted to have spilled liquids and a build up of black dirt/debris on the rubber bumper around the perimeter of the cart. The central medication cart was also noted to have a pin liquid spilled down the back of the cart. The medication crusher on each of the medication carts were observed to have a build up of a black dirt/debris on them.
Further observation revealed that treatment carts on both home areas were also kept unclean and untidy.

The above observations were confirmed with the Registered Practical Nurse working in the central medication room and the Registered Nurse confirmed the observations in the north medication room.

Record review of the medication management system program evaluation dated December 2014 revealed that it was identified that the medication rooms were not kept tidy and clean and this was noted as an area of improvement.

During an interview with the Registered Practical Nurse they stated they were not sure if there was a cleaning schedule for the medication cart but acknowledged that the cart should be cleaned after each medication pass. The Registered Practical Nurse further stated that the pill crusher had been kept clean but the dirt was built in. The Registered Practical Nurse then wiped the pill crusher with a wet wipe and it turned grey-black as it removed dirt form the crusher.

The Director of Care confirmed that they had also observed the medication carts to be unclean and untidy and reported that they had issued a memo on July 16, 2015 to the registered staff to ensure the medication carts and the treatments carts were kept clean after the medication pass. (532)

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

May 02, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s.15.(2)(c).

The plan must include what immediate and long term actions will be undertaken to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. The plan must also include who will be responsible to correct the areas of non-compliance and the dates for completion.

Please submit the plan, in writing quoting log number 019819-15, to Sharon Perry, Long Term Care Homes Inspector - Nursing, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, by email, at Sharon.Perry@Ontario.ca by November 27, 2015.

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

Grounds / Motifs :

1. This has been previously issued as a written notification, voluntary plan of correction and compliance order #005 on November 24, 2014 during inspection 2014_202165_0029.

During the initial tour of the home and throughout this inspection the following was observed.
a) The flooring in the elevator was noted to have some cracked and chipped tiles.
b) The central activity room had flooring tiles missing under the new heater.
c) Dry wall damage was noted in the hallway between room 208, 210 and 212; central tub room; clean utility room between room 228-230; the north tub room; and in four identified resident rooms/bathrooms.
d) The half wall in the shower area of the central tub room had cracked and missing tiles.
e) Baseboards were missing in two identified resident rooms.
f) Baseboards were coming off in six identified resident rooms/bathrooms.
g) Wall protect was peeling off the walls in three identified resident rooms.
h) Corner protect was broken on the door to the small dining room and metal edges were exposed.
j) Paint was chipped on the bathroom doors and/or frames to six identified resident rooms.
k) The flooring at the base of the toilets were noted to be brown and there was no caulking to seal the flooring. This was noted in 11 identified bathrooms.

During a tour of the home with the Environmental Services Supervisor they acknowledged and confirmed that the home needed many repairs done and that the home and furnishings were not maintained in a good state of repair.

(155)

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

Jun 30, 2016

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

Ministère 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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 16 day of March 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY - (A1)

Service Area Office /
Bureau régional de services : London