Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2020	2020_715672_0017	016335-20, 017347-20, 020155-20, 020640-20	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Oshawa
82 Park Road North OSHAWA ON L1J 4L1

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 3-6 and 9, 2020

The following intakes were completed during this inspection:

Four intakes related to critical incident reports regarding resident falls resulting in injuries and significant changes of condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI Coordinator, Social Worker, Quality Control Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapists (PT) and physio assistants (PTA), Housekeepers and residents.

The inspector reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Restraints and PASDs, Pain Assessments and Medication Administration. The Inspector also observed staff to resident care and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 residents were assessed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions.

Resident #003 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with a specified injury. Review of resident #003's electronic Medication Administration Records (eMARs) indicated the resident had a narcotic analgesic ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #003 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Both pharmacological and non-pharmacological interventions were implemented, with fair effect, but there were times when the resident continued to experience discomfort, despite the interventions which were implemented.

Review of the internal policy related to pain identification and management directed that pain assessments were expected to be completed upon admission to the home and hospital readmission, with any new pain or new diagnosis of a painful disease, when a new pain medication was started, when a new non-pharmacological intervention was initiated and/or when breakthrough pain medication was used for three consecutive days.

During separate interviews, PSW #107 and RPN #118 indicated that resident #003 had frequent complaints of pain following the identified fall, which they had a new analgesic ordered to assist with. PSW #107 further indicated they often approached the registered staff to have the analgesic administered prior to assisting the resident with personal care and/or transferring. RPN #118 indicated the expectation in the home was for pain assessments to be completed upon admission/readmission to the home, following any fall with injury, any new resident complaint of pain and any new analgesic order and/or if the analgesic was not successful in managing a resident's pain level. RPN #118 further indicated they were unaware if a pain assessment had been completed for resident #003 following their fall, readmission from hospital or new analgesic order. Inspector reviewed resident #003's health care record following the identified fall and did not observe any pain assessment completed for the resident after the fall, readmission from hospital, with the resident's ongoing complaints of pain, when they had new pain analgesics ordered or when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

Related resident #004:

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Review of resident #004's eMARs indicated the resident had a pain medication ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #004 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Inspector reviewed resident #004's health care record following the fall, and did not observe any pain assessment completed for the resident after the identified fall, readmission from hospital, with the resident's verbal and nonverbal signs of pain, when new pain medications were ordered nor when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

During separate interviews, PSW #115 and RPN #101 indicated that resident #004 had frequent complaints of pain following the identified fall, which they had a new analgesic ordered to assist with. RPN #101 further indicated they were aware of the expectation in the home regarding when pain assessments were supposed to be completed but was unaware if a pain assessment had been completed for resident #004 following their fall, readmission from hospital or new analgesic order.

Related resident #001:

Resident #001 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with an identified injury. Review of resident #001's eMARs indicated the resident had several new pain medications ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #001 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Inspector reviewed resident #001's health care record following the identified fall, and did not observe any pain assessment completed for the resident after the fall, readmission from hospital, with the resident's verbal and nonverbal signs of pain, when new pain medications were ordered nor when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

During separate interviews, PSW #115 and RPN #101 indicated that resident #001 exhibited verbal and non-verbal signs and symptoms of pain following the identified fall, which they had new analgesics ordered to assist with. RPN #101 further indicated they were aware of the expectation in the home regarding when pain assessments were supposed to be completed but was unaware if a pain assessment had been completed for resident #001 following their fall, readmission from hospital or new pain medication orders.

During an interview, the DOC indicated the expectation in the home was for pain assessments to be completed upon admission to the home and hospital readmission, with any new pain or new diagnosis of a painful disease, when a new pain medication was started, when a new non-pharmacological intervention was initiated and/or when breakthrough pain medication was used for three consecutive days. Inspector reviewed resident #003, #004 and #001's electronic health care record following each of their falls and the DOC verified pain assessments had not been completed, as per the expectation of the home and internal pain management policy.

Sources: Observations of resident #003, #004 and #001, internal policy related to pain identification and management, interviews with PSWs #107 and #115, RPNs #101 and #118 and the DOC. [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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when they no longer utilized a specified fall prevention intervention.

Resident #002 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with an identified injury. Resident #002 was noted to be at risk for falling and had their plan of care reviewed and revised following the fall, which listed an identified fall prevention intervention in their plan of care. During resident observations, Inspector observed resident #002 over a specified period of time and did not observe the resident to have the identified fall prevention intervention implemented at any time.

During separate interviews, PSWs #106 and #125 indicated that resident #002 had not utilized the identified fall prevention intervention for several weeks, which had been communicated to the registered staff. RPN #104 indicated they were aware that resident #002 had not been utilizing the identified fall prevention intervention recently but had not removed them from the resident's fall prevention interventions.

During an interview, the DOC indicated the expectation in the home was for PSW staff to report if a resident was refusing an intervention listed in their plan of care to registered staff. The registered staff were to encourage and educate the resident to accept the intervention, and if unsuccessful, were to document the refusal in the resident's progress notes. If a resident consistently refused an intervention despite encouragement and education, the intervention was to be removed from the resident's plan of care, accompanied by documentation which indicated the intervention had been offered/trialed and the reasons the implementation had been unsuccessful. By not ensuring resident #002's plan of care was reviewed and revised when they no longer utilized the identified fall prevention intervention, they were placed at risk of not having fall prevention interventions implemented as required.

Sources: Observations of resident #002, resident #002's written plan of care, interviews with PSWs #106 and #125, RPN #104 and the DOC. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident's plans of care are reviewed and revised when they no longer utilize fall prevention interventions, to be implemented voluntarily.

WN #3: 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 the internal head injury routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal policy related to head injury routines indicated that when a resident was placed on head injury routine assessment, staff were to follow the time frames indicated on the form unless specific physician's orders were received which stated

otherwise. The policy further stated the rationale for the assessment was that early recognition of some neurological observations and their treatments provided the best chance of halting deterioration before irreversible damage developed.

Resident #001 was noted to be at high risk for falls and sustained an identified number of falls during a specified time period, some of which resulted in the resident being placed on head injury routine (HIR). On an identified date, resident #001 sustained a fall which resulted in a specified injury, therefore they were placed on head injury routine. Upon review of the head injury routine assessments, Inspector observed that none of them had been completed in full, as directed in the internal policy. During an interview, Inspector reviewed the information missing from the head injury routine assessments for resident #001, and the DOC verified the assessments had not been completed according to the internal head injury routine policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Specified critical incident report, internal policy related to head injury routines, resident #001’s Clinical Monitoring Record - V 4 assessments, interviews with DOC and other staff.

Related resident #002:

Resident #002 was noted to be at high risk for falls and sustained an identified number of falls during a specified time period, some of which resulted in the resident being placed on head injury routine (HIR). On an identified date, resident #002 sustained a fall which resulted in a specified injury, therefore they were placed on head injury routine. Upon review of the head injury routine assessments, Inspector observed that some of them had not been completed in full, as directed in the internal policy. During an interview, Inspector reviewed the information missing from the head injury routine assessments for resident #002, and the DOC verified the assessments had not been completed according to the internal head injury routine policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Specified critical incident report, internal policy related to head injury routines, resident #002’s Clinical Monitoring Record - V 4 assessments, interviews with DOC and other staff.

Related resident #003:

Resident #003 was noted to be at risk for falls and sustained an identified number of falls during a specified time period, some of which resulted in the resident being placed on head injury routine (HIR). On an identified date, resident #003 sustained a fall which resulted in a specified injury, therefore they were placed on head injury routine. Upon review of the head injury routine assessments, Inspector observed that some of them had not been completed in full, as directed in the internal policy. During an interview, Inspector reviewed the information missing from the head injury routine assessments for resident #003, and the DOC verified the assessments had not been completed according to the internal head injury routine policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Specified critical incident report, internal policy related to head injury routines, resident #003's Clinical Monitoring Record - V 4 assessments, interviews with DOC and other staff.

Related resident #004:

Resident #004 was noted to be at high risk for falls and sustained an identified number of falls during a specified time period, some of which resulted in the resident being placed on head injury routine (HIR). On an identified date, resident #004 sustained a fall which resulted in a specified injury, therefore they were placed on head injury routine. Upon review of the head injury routine assessments, Inspector observed that some of them had not been completed in full, as directed in the internal policy. During an interview, Inspector reviewed the information missing from the head injury routine assessments for resident #004, and the DOC verified the assessments had not been completed according to the internal head injury routine policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Specified critical incident report, internal policy related to head injury routines, resident #004's Clinical Monitoring Record - V 4 assessments, interviews with DOC and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including pain.

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Review of resident #004's eMARs indicated the resident had a narcotic analgesic ordered upon their return to the home from hospital. During resident observations, Inspector observed resident #004 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Both pharmacological and non-pharmacological interventions were implemented but there were times when the resident continued to experience discomfort, despite the interventions which were implemented. Inspector reviewed resident #004's electronic health care record and written plan of care and could not locate any focus specific to pain management.

Review of the internal policy related to pain identification and management stated registered staff were expected to ensure the plan of care was reviewed and updated with the resident's goals and treatment plan at a minimum of quarterly or with any change to the treatment plan.

During separate interviews, PSW #115 and RPN #101 indicated that resident #004 had frequent complaints of pain following the identified fall, which they had a new pain medication ordered to assist with. RPN #101 further indicated that when a resident had ongoing complaints of pain, with interventions implemented in an attempt to relieve the pain, the resident should have a focus specific to pain and the associated interventions in the written plan of care.

During separate interviews, RPN #104, who was one of the RAI Coordinators in the home, and the DOC indicated the expectation in the home was for a resident to have a care plan focus specific to pain management within their written plan of care when a resident had frequent complaints of pain, was receiving pain medications and/or was diagnosed with a painful disease or condition such as a fracture. The plan of care related to pain was also expected to include goals for the resident's pain management treatment plan and interventions to implement to assist in relieving the resident’s pain.

Sources: Observations of resident #004, internal policy related to pain identification and management, interviews with PSW #115, RPNs #101 and #104 and the DOC. [s. 26. (3) 10.]

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 residents' plans of care are based on an interdisciplinary assessment with respect to the residents' health conditions, including pain, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #004 was restrained by a physical device, that the restraint was included in the resident's plan of care.

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Following resident #004's return to the home from hospital, the resident had an identified restraint implemented in order to prevent the resident from self transferring and mobilizing independently, in an attempt to prevent further falls from occurring. According to the progress notes, this intervention was implemented on a specified date, as per the resident's POA request. Inspector reviewed resident #004's electronic health care record but did not observe any documentation or plan of care related to the purposes, goals or directions to the staff regarding the application of resident #004's identified restraint.

During separate interviews, RPN #101 and the DOC indicated the expectation in the home was for a plan of care to be created and documented prior to the implementation of any resident being restrained by a physical device. The DOC further indicated that restraint care plans were expected to include the type of restraint being utilized, when, how and for how long the restraint was supposed to be implemented, the goal of restraint reduction and clearly detailed uses of the restraint. Inspector reviewed resident #004's

health care record with the DOC and they verified the resident did not have the expected plan of care documented related to their identified restraint.

By not ensuring resident #004 had a plan of care related to their identified restraint, the resident was placed at increased risk of being restrained inappropriately and/or sustaining injuries as a result of possible inappropriate implementation of the restraint.

Sources: Observations of resident #004, resident #004's specified written plan of care, resident #004's specified MDS assessment, and interviews with RPN #101 and the DOC. [s. 31. (1)]

2. The licensee has failed to ensure that when resident #004 was restrained by a physical device, that alternatives to the restraint were considered and tried prior to the implementation of the restraint.

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Following resident #004's return to the home from hospital, the resident had an identified restraint implemented in order to prevent the resident from self transferring and mobilizing independently, in an attempt to prevent further falls from occurring. According to the progress notes, this intervention was implemented on a specified date, as per the resident's POA request. Inspector reviewed resident #004's health care records but did not observe any documentation or plan of care related to any alternatives to the restraint which were considered and trialed prior to the implementation of resident #004's identified restraint.

During separate interviews, RPNs #101 and #102 indicated resident #004's identified restraint had been implemented as a result of a request by the resident's Power of Attorney (POA), following the fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. RPNs #101 and #102 further indicated they could not recall any alternatives to the restraint being considered and/or trialed prior to the implementation of the identified restraint, between when the resident's POA requested the identified restraint and when it was physically implemented and believed the identified restraint was implemented very quickly following the POA's request.

During an interview, the DOC indicated the expectation in the home was that prior to a restraint being implemented, a restraint assessment was expected to be completed. This assessment was expected to include a multidisciplinary discussion with supporting documentation related to restraint alternatives which had been considered and trialed

prior to the implementation of a restraint. The DOC further indicated that restraints were only supposed to be implemented after all other restraint alternatives had been considered, trialed and deemed unsuccessful, as the home had adopted a 'least restraints' philosophy. Inspector reviewed resident #004's health care record with the DOC and they verified there was no documentation to support that previous restraint assessments or alternatives had been considered, trialed and deemed unsuccessful for resident #004, prior to the identified restraint being implemented.

By not ensuring that alternatives to the restraint were considered and trialed prior to the implementation of the identified restraint, the resident was placed at increased risk of being restrained inappropriately.

Sources: Observations of resident #004, resident #004's health care record, and interviews with RPNs #101, #102 and the DOC. [s. 31. (2) 2.]

3. The licensee has failed to ensure that resident #004's plan of care related to restraints included an order by the physician or a registered nurse in the extended class.

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Following resident #004's return to the home from hospital, the resident had an identified restraint implemented in order to prevent the resident from self transferring and mobilizing independently, in an attempt to prevent further falls from occurring. According to the progress notes, this intervention was implemented on a specified date, as per the resident's POA request. Inspector reviewed resident #004's health care records on an identified date, but did not observe an order by the physician or the registered nurse in the extended class related to the resident's identified restraint. Inspector then reviewed the internal policy related to restraints, which stated resident health care records must be kept current and updated with orders, strategies, assessments and interventions put in place to document any application of a physical restraint.

During separate interviews, PSW #115 and RPN #101 indicated that resident #004 had an identified restraint implemented following the fall which resulted in identified injuries. RPN #101 further indicated the expectation in the home was for an order to be received from the physician prior to the implementation of any restraint.

During an interview, the DOC indicated that an order had not been received for resident #004's identified restraint until after the Inspector brought to the attention of staff that an

order could not be located. The DOC further indicated the expectation in the home was for an order by the physician to be received prior to the implementation of any restraint and verified this had not been completed for resident #004. The Inspector then reviewed the physician's order which was obtained and noted the order did not include instructions related to when the restraint should be implemented or for how long the restraint should be used for. By not ensuring an order was received prior to implementing resident #004's identified restraint, the resident was placed at risk of not being given the most appropriate device and may have been placed at risk for injury.

Sources: Observations of resident #004, internal policy related to restraints, interviews with PSW #115, RPN #101 and the DOC. [s. 31. (2) 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 when residents are restrained by a physical device the restraint is included in the resident's plan of care; restraint plans of care include an order by a physician or registered nurse in the extended class and prior to implementation of a restraint, alternatives are considered and trialed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that PASDs used to assist residents #003 and #001 with routine activities of living were included in the residents' plan of care.

Resident #003 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with a specified injury. Following resident #003's return to the home from hospital, the resident had an identified device implemented in an attempt to prevent the resident from self transferring, mobilizing independently and promote comfort.

During resident observations, Inspector observed resident #003 had an identified device implemented for extended periods of time. Inspector reviewed the internal policy related to Personal Assistance Service Devices (PASDs), which indicated the resident's care plan was expected to state the purpose and timeframe for the use of the PASD, documented approval for the PASD to be utilized and the monitoring, response and repositioning of the resident from the PASD. Inspector then reviewed resident #003's physical and electronic health care record, and did not observe a focus specific to the usage of a PASD in their written plan of care nor any documentation related to an approval or consent related to the usage of the PASD; any alternatives trialed instead of the PASD; the resident's response to or repositioning from the PASD.

During separate interviews, PSW #107 and RPN #118 indicated resident #003 had the identified device implemented routinely when up from bed, in order to assist in preventing the resident from self transferring and mobilizing independently. PSW #107 further indicated that when the PASD was implemented, it also assisted in reducing resident #003's pain from related to the identified injury from the fall. Lastly, PSW #107 indicated staff did not document on resident #003's utilization of the PASD intervention. RPN #118 indicated the expectation in the home was for a resident to have a focus specific to PASDs in their written plan of care if they utilized a PASD for an activity of daily living, comfort or positioning. RPN #118 further indicated that resident #003's identified device did assist the resident with positioning and comfort, which met the definition of a PASD, but the home did not consider resident #003's implemented intervention to be a PASD.

Related to resident #001:

Resident #001 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with an identified injury. Following resident #001's return to the home from hospital, the resident had an identified device implemented in an attempt to prevent the resident from self transferring, mobilizing independently and promote comfort.

During resident observations, Inspector observed resident #001 with the identified device implemented for extended periods of time. Inspector reviewed resident #001's physical and electronic health care record, and did not observe a focus specific to the usage of a

PASD in their written plan of care nor any documentation related to an approval or consent related to the usage of the PASD; any alternatives trialed instead of the PASD; the resident's response to or repositioning from the PASD.

During separate interviews, PSW #115 and RPNs #101 and #102 indicated resident #001 had the identified device implemented routinely when up from bed, in order to assist in preventing the resident from self transferring, mobilizing independently and promote comfort. RPNs #101 and #102 further indicated the expectation in the home was for a resident to have a focus specific to PASDs in their written plan of care, if they utilized a PASD for an activity of daily living, comfort or positioning. RPNs #101 and #102 indicated that resident #001's identified device did assist the resident with positioning and comfort, which met the definition of a PASD, but the home did not consider resident #001's identified device to be a PASD.

During an interview, the DOC indicated the expectation in the home was for a resident to have a focus specific to PASDs in their plan of care if one was utilized by the resident for assistance with an activity of daily living and/or for comfort purposes. The DOC reviewed the purposes residents #001 and #003 utilized the identified devices and acknowledged that each met the definition of a PASD, therefore should have had a documented approval, consent and focus within the written plan of care for each resident specific to utilization of the tilt wheelchair as a PASD. By not ensuring that residents #001 and #003 had the PASD added to their plan of care, the residents were placed at risk of having the PASD inappropriately implemented.

Sources: Observations of residents #001 and #003, internal policy related to Personal Assistance Service Devices (PASDs), interviews with PSWs #107 and #115, RPNs #101, #102 and #118 and the DOC. [s. 33. (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 PASDs used to assist residents with routine activities of living are included in the residents' plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff released resident #004 from the physical device and repositioned them at least once every two hours.

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Following resident #004's return to the home from hospital, the resident had an identified restraint implemented in order to prevent the resident from self transferring and mobilizing independently, in an attempt to prevent further falls from occurring. According to the progress notes, this intervention was implemented on a specified date, as per the resident's POA request. During resident observations, Inspector did not observe resident #004 being repositioned or the identified restraint being released every two hours.

During separate interviews, PSW #115 and RPN #101 indicated resident #004's identified restraint was not removed and the resident was not repositioned by staff at a minimum of every two hours because resident #004 was able to reposition themselves while sitting in the wheelchair. PSW #115 and RPN #101 further indicated that due to the resident being able to shift their weight independently in their seat, the identified restraint was not released every two hours, as it was only released when the resident was assisted to the bathroom or into the bed.

During an interview, the DOC indicated the expectation in the home was for a restraint to be released and resident repositioned at a minimum frequency of every two hours, but if a resident was able to reposition themselves within a wheelchair when a restraint was applied, they did not require release of the restraint and repositioning every two hours.

By not ensuring the resident was released from the physical device and repositioned at least once every two hours, the resident was placed at risk of experiencing increased discomfort and skin impairment.

Sources: Observations of resident #004, interviews with PSW #115, RPN #101 and the DOC. [s. 110. (2) 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 when residents are physically restrained, they are released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #8: 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 that was secure and locked.

During resident observations, Inspector #672 observed several baskets filled with numerous medicated treatments and creams being stored on top of the desk of the nursing station on the second and third floors and several medicated creams left out on top of the desk of the nursing station on the first floor. Inspector #672 also observed the key to the treatment carts, which stored medicated treatments and creams were attached to the side of the treatment carts on the second and third floors and was located on the wall of the nursing station on an identified resident home area.

During separate interviews, RNs, #100 and #105, RPNs #101, #102, #103, #108 and #118 and PSWs #107, #109, #111 and #116 indicated it was a regular practice in the home for the medicated treatments and creams to be stored on top of the desk of the nursing stations on two identified resident home areas. The key to the treatment carts were either attached to the side of the treatment carts or stored on the wall of the nursing stations on the identified resident home areas, for easy access for both registered and non-registered nursing staff. During an interview with the DOC, they verified the information provided by the nursing staff related to the key to the treatment carts being stored on the walls at the nursing stations. The DOC indicated the medicated treatments and creams were to be stored in the treatment carts following application, which was why the key to the treatment carts were supposed to be stored on the walls at the nursing stations, for easy access to the carts for all staff, both registered and non-registered. The DOC further verified that it was routine for residents to be sitting around the nursing stations on each of the resident home areas (RHAs) and each of the RHAs had residents who were known to wander.

Following an interview, the DOC indicated all medications and medicated creams would be removed from the nursing stations and stored in a locked area and the keys to the treatment carts would be kept with registered staff members only. On a later identified date, Inspector #672 conducted a follow up observation and noted there were still medications and medicated creams left unsecure on two identified resident home areas and the keys to the treatment carts were still being stored on the wall of the nursing station on identified resident home areas.

Sources: Observations completed during a specified time period, interviews with PSWs #107, #109, #111 and #116, RPNs #101, #102, #103, #108 and #118, RNs #100 and #105 and the DOC. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #9: 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 has failed to ensure that staff participated in the implementation of the infection prevention and control program in the home, related to hand hygiene.

During specified resident observations, Inspector #672 observed part of the lunch meals and afternoon nourishment passes on each of the resident home areas (RHAs). During the observations at the beginning of the lunch meal on two identified resident home areas, Inspector did not observe any hand hygiene being offered or completed on any of the residents prior to consuming their meal. During the observations of the afternoon nourishment passes on each of the RHAs in the home, the Inspector did not observe staff completing hand hygiene between assisting residents with their nourishment nor offering hand hygiene to any resident prior to consuming the nourishment.

During separate interviews, PSWs #109, #110, #111, #112, #113, #114, #115 and #116 indicated their usual practice was to complete hand hygiene at the beginning and end of the nourishment pass and acknowledged that they did not complete hand hygiene prior to or after assisting each resident, even after they had assisted residents with intake of their nourishment and/or had removed used lunch trays from the resident's rooms.

During separate interviews, RN# 105, RPNs #101 and #118 and PSWs #112, #113, #117, #122, #123 and #124 indicated the expectation in the home was for hand hygiene to be offered/completed for each resident before entering the dining room to consume the upcoming meal.

During an interview, the DOC indicated the expectation in the home was for hand hygiene to be offered and completed for each resident prior to entering the dining room for each meal and for staff to complete hand hygiene prior to and after assisting each resident with consuming their nourishment from the snack carts. The DOC further indicated that all staff in the home had received education related to the expectations in the home related to hand hygiene, which was reviewed on an annual basis, at a minimum.

Sources: Observations completed during a specified period of time, interviews with PSWs #109, #110, #111, #112, #113, #114, #115, #116, #117, #122, #123 and #124, RPNs #101 and #118, RN #105 and the DOC. [s. 229. (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 staff participate in the implementation of the infection prevention and control program in the home, to be implemented voluntarily.

Issued on this 27th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2020_715672_0017
Log No. / No de registre :	016335-20, 017347-20, 020155-20, 020640-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 24, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Oshawa 82 Park Road North, OSHAWA, ON, L1J-4L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah Woods

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / No d'ordre : 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) from O. Reg 79/10 of the LTCHA.

Specifically, the licensee must:

1) Re-educate the registered nursing staff on the internal pain management policy entitled "Pain Identification and Management"; policy #RC-19-01-01; last updated: December 2019, and the expectations regarding when pain assessments are to be completed. A documented record must be kept.

2) Ensure that residents #001, #003, #004 and any other resident identified in the home with unrelieved pain are assessed using a clinically appropriate assessment instrument.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were assessed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions.

Resident #003 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with a specified injury. Review of resident #003's electronic Medication Administration Records (eMARs) indicated the resident had a narcotic analgesic ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #003 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Both pharmacological and non-pharmacological interventions

were implemented, with fair effect, but there were times when the resident continued to experience discomfort, despite the interventions which were implemented.

Review of the internal policy related to pain identification and management directed that pain assessments were expected to be completed upon admission to the home and hospital readmission, with any new pain or new diagnosis of a painful disease, when a new pain medication was started, when a new non-pharmacological intervention was initiated and/or when breakthrough pain medication was used for three consecutive days.

During separate interviews, PSW #107 and RPN #118 indicated that resident #003 had frequent complaints of pain following the identified fall, which they had a new analgesic ordered to assist with. PSW #107 further indicated they often approached the registered staff to have the analgesic administered prior to assisting the resident with personal care and/or transferring. RPN #118 indicated the expectation in the home was for pain assessments to be completed upon admission/readmission to the home, following any fall with injury, any new resident complaint of pain and any new analgesic order and/or if the analgesic was not successful in managing a resident's pain level. RPN #118 further indicated they were unaware if a pain assessment had been completed for resident #003 following their fall, readmission from hospital or new analgesic order. Inspector reviewed resident #003's health care record following the identified fall and did not observe any pain assessment completed for the resident after the fall, readmission from hospital, with the resident's ongoing complaints of pain, when they had new pain analgesics ordered or when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

Related resident #004:

Resident #004 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with identified injuries. Review of resident #004's eMARs indicated the resident had a pain medication ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #004 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Inspector reviewed resident #004's health care record following the fall, and did not observe any pain assessment completed for the resident after the identified fall, readmission from hospital, with the resident's verbal and nonverbal signs of pain, when new pain medications were ordered nor when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

During separate interviews, PSW #115 and RPN #101 indicated that resident #004 had frequent complaints of pain following the identified fall, which they had a new analgesic ordered to assist with. RPN #101 further indicated they were aware of the expectation in the home regarding when pain assessments were supposed to be completed but was unaware if a pain assessment had been completed for resident #004 following their fall, readmission from hospital or new analgesic order.

Related resident #001:

Resident #001 sustained a fall which resulted in the resident being transferred to hospital and diagnosed with an identified injury. Review of resident #001's eMARs indicated the resident had several new pain medications ordered upon their return to the home from hospital.

During resident observations, Inspector observed resident #001 exhibited verbal and non-verbal signs and symptoms of pain, which was reported to the registered staff. Inspector reviewed resident #001's health care record following the identified fall, and did not observe any pain assessment completed for the resident after the fall, readmission from hospital, with the resident's verbal and nonverbal signs of pain, when new pain medications were ordered nor when the analgesics were utilized for more than three days in a row. By not completing a pain assessment for the resident when required, the resident was placed at increased risk of suffering ongoing, unrelieved pain.

During separate interviews, PSW #115 and RPN #101 indicated that resident #001 exhibited verbal and non-verbal signs and symptoms of pain following the

identified fall, which they had new analgesics ordered to assist with. RPN #101 further indicated they were aware of the expectation in the home regarding when pain assessments were supposed to be completed but was unaware if a pain assessment had been completed for resident #001 following their fall, readmission from hospital or new pain medication orders.

During an interview, the DOC indicated the expectation in the home was for pain assessments to be completed upon admission to the home and hospital readmission, with any new pain or new diagnosis of a painful disease, when a new pain medication was started, when a new non-pharmacological intervention was initiated and/or when breakthrough pain medication was used for three consecutive days. Inspector reviewed resident #003, #004 and #001's electronic health care record following each of their falls and the DOC verified pain assessments had not been completed, as per the expectation of the home and internal pain management policy.

Sources: Observations of resident #003, #004 and #001, internal policy related to pain identification and management, interviews with PSWs #107 and #115, RPNs #101 and #118 and the DOC.

An order was made by taking the following factors into account:

Severity: Residents #001, #003 and #004 were noted to have ongoing complaints of pain. By not completing a pain assessment for the residents when required, they were placed at increased risk of suffering ongoing, unrelieved pain.
Scope: The incident was identified to be wide spread, as three out of three residents in the home were affected.
Compliance History: One voluntary plan of correction (VPCs) was issued to the home related to the same section of the legislation in the past 36 months during a Resident Quality Inspection issued in October 2018. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 24th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office