Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2015	2015_376594_0005	S-000279-14, S-000280-14, S-000281-14	Follow up

Licensee/Titulaire de permis

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

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

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

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

MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 04-06, 2015

This inspection was conducted concurrently with Complaint Inspection 2015_376594_0006 and Critical Incident System Inspection 2015_376594_0007.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Dietary staff, Housekeeping staff, Nursing Informatics Assistant, Quality Management Coordinator, Executive Assistant to the Director of Nursing & Personal Care, Behavioural Restorative Team (BRT) Clinical Lead, Registered Practical Nurses (RPNs), Registered Nurse (RN), Social Service Manager, Assistant Director of Nursing, Director of Nursing & Personal Care and the Administrator.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted daily walk through of the resident care areas and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Skin and Wound Care
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).

5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received training as outlined in this Act before performing their responsibilities and annually thereafter.

During Resident Quality Inspection, 2014_332575_0008, Compliance Order #002 was issued stating the licensee was to ensure that all staff received training, and annual re-training of infection prevention and control, to be complied with by September 30, 2014. A complaint was also received by the Director in January 2015, which stated that there is

a lack of training in the home for staff to know what to do and how to care for the residents correctly during an outbreak.

A.Annual Re-training:
The inspector reviewed the Infection Prevention and Control staff training records from January 01, 2014, to September 30, 2014. The training records were compared to the number of staff available, 145 to complete the course, as provided by the DONPC. Training records for hand hygiene, chain of transmission, personal protective equipment (PPE's) and cleaning, as well as disinfection practices were reviewed. It was determined that:
- 0/145 staff, or 0% of staff, completed the Hand Hygiene Policy and Procedure training, but that 43/145 staff, or 30% of staff, completed a hand hygiene demonstration on August 01, 2014;
- 18/145 staff, or 12% of staff, completed the Chain of Transmission Policy and Procedure training;
- 48/145 staff, or 33% of staff, completed the Personal Protective Equipment Policy and Procedure training including a PPE demonstration on August 01, 2014;
- Cleaning and disinfection practices training records were broken down into the following courses:
- Module 2 Routine Practices: 47/145 staff, or 32% of staff
- Module 4a General Cleaning Frequency: 79/145 staff, or 55% of staff
- Module 4b General Cleaning Procedures: 75/145 staff, or 52% of staff
- Module 4c General Cleaning Other considerations: 73/145 staff, or 50% of staff

Review of the home's Infection Prevention and Control (IPC) Mandatory Education Program policy #IPC-EDU-030 reviewed January 2015 stated the IPC Education Program at Lakeland LTC has a Mandatory Component to be reviewed annually by employees including but not limited to: The Chain of Transmission, Hand Hygiene, and PPEs.

B. Training before performing responsibilities:
The inspector reviewed the home's New Staff Orientation policy #O.P. 14 issued September 2010 which stated newly hired employees are provided the following supports and education: orientation days, orientation checklist, orientation education day, as well as informal and formal mentoring. The policy went on to further state that both PSWs and Nursing Managers are provided six orientation shifts, and that during orientation shifts, new employees will be "buddied" with an experienced staff member and an orientation day will be scheduled twice yearly or more often as required. According to

the same policy, the orientation day is a formal education session covering the following topics (including but not limited to): Mission/Vision/Values, Codes of Conduct and Lakeland Spirit, Fire Drills and Evacuation, Resident Care/Resident Incidents, Resident Rights/Resident Abuse and Infection Prevention and Control/Isolation.

In an interview with the inspector, the ADON stated that the orientation process for a new staff hire in the nursing department is as follows: The new staff member's first day at the home is to work with a buddy in a home area observing. During the first day, the new staff member is provided a learning package (SURGE learning) by the Quality Management Coordinator who gives direction on how to access and use SURGE learning, and discusses the time limit to complete all the required orientation learning. On the second day, the new staff member is performing duties, while completing an orientation checklist within a designated period of time. If concerns are identified with the new staff member, the buddy person will report those concerns about the new staff member, to the DONPC and/or ADON.

During an interview with the inspector, the Quality Management Coordinator stated that staff have one month from the day they receive their orientation package (SURGE learning, also referred to as the Day Two package), to complete the package. The Quality Management Coordinator also stated the Orientation Day (Day One/Orientation Education Day) in-service, only occurs a couple times a year. The Quality Management Coordinator provided the inspector with the Annual House wide Training/Day One in-service record for 2014 with the following dates: March 18, 19th and March 25, 26th, 2014.

The inspector reviewed the Day One Orientation Agenda which outlines training on the home's Mission, Vision and Values, Resident Care – Essential Tools, Resident Safety, Staff Health and Safety, Education and Continual Learning and Professionalism. Review of the Day Two Orientation package by the inspector, states Day Two is an independent participation training day of which the requirement is to complete a number of policy & procedure reviews, quizzes and online learning modules. The inspector reviewed the Day Two Orientation Checklist: Policy and Procedure Review which identifies the following policy and procedures (including but not limited to): Abuse, Infection Prevention & Control Program and Principles of Additional Precautions & Rationale.

In an interview with the inspector, s#-109 stated they were hired one month earlier and their first day was shadowing another staff member and they provided resident care. S#-109 further stated they were told they have as long as needed to complete the

orientation checklist, and were allowed to ask for more time if needed. When asked by the inspector regarding certain training topics, s#-109 stated they have not been trained on the homes Mission statement, but there were a lot of policies to go through and it may have been in one of those.

The inspector reviewed s#-127's Day Two Orientation Checklist which stated policy and procedure review was completed three months later.

Given that not all staff completed the required annual retraining prior to the compliance order date of September 30, 2014, and that staff performed duties prior to receiving training, the licensee has failed to comply with Compliance Order #002 and to ensure that all staff had received training before performing their responsibilities. [s. 76. (2)]

2. The licensee has failed to ensure that all staff receive retraining annually on the home's policy to promote zero tolerance of abuse and neglect of residents. In an interview with the inspector, s#-106 stated they had been trained on the home's policy to promote zero tolerance of abuse but was not sure when that last occurred. The inspector reviewed the training records for the home's policy to promote zero tolerance of abuse and neglect of residents for the period of January 01, 2014 to December 31, 2014, and found that 10 of 143, or 7% of staff completed training on the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

3. The licensee has failed to ensure that all staff who provided direct care to residents, received training in the restraining of residents and in other areas provided for in the regulations such as skin and wound care. During Resident Quality Inspection, 2014_332575_0008, Compliance Order #003 was issued stating the licensee was to ensure that all staff who provided direct care to residents receive annual training on skin and wound care and how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

In an interview with the inspector, s#-115, stated when they were hired they may have had some training on restraints but doesn't feel they had much training. S#-109 stated to the inspector, they had been hired one month earlier and has had no hands on training on restraints but there was information on Surge Learning.

The inspector reviewed the home's Minimizing Restraining of Residents: Use of Restraints policy #RSL-SAF-035 effective June 2014, which stated staff who provide direct care to residents must receive annual retraining on restraint policies and

procedures and the correct use of equipment as it relates to their jobs. Staff who provide direct care to residents must receive orientation and annual training on minimizing restraining of residents. According to the same document, orientation and training includes registered staff oriented and trained using on-line training or equivalent on least/minimizing restraints, hands on instruction and practice on correct use of physical restraints using "Train-the-Trainer" methodology. Staff were also required to review Lakeland LTC's restraint policy and procedure "RSL-SAF-035 Minimizing Restraining of Residents: Use of Restraints", and Lakeland LTC's minimizing of restraint program "Least Restraint Program".

During an interview with the inspector, the ADON confirmed "Train-the-Trainer" methodology was used in training staff related to restraint use. Registered staff will train other registered staff and PSWs with hands on instruction and practice on correct use of physical restraints, but registered staff do not sign off on any documentation stating a staff member has received hands on instruction.

The inspector reviewed the skin and wound care as well as restraint staff training records from January 01, 2014, up until September 30, 2014. The training records were compared to the number of direct care staff available, 105 staff members were required to complete the training. The following was determined:
- 38/105 staff, or 36% of staff completed Skin and Wound Care Program training

Restraint training records were broken down into the following courses:
- 58/105 staff, or 55% of staff completed Restraints Policy and Procedures
- 65/105 staff, or 62% of staff completed Restraint and PASDs by Surge Learning Video
- 57/105 staff, or 54% of staff completed Least Restraints Program 2014 [s. 76. (7)]

Additional Required Actions:

CO # - 001, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 where required, the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the Act.

During Resident Quality Inspection, #2014_332575_0008, Compliance Order #002 was issued stating the licensee was to ensure that all staff received training, and annual re-training of infection prevention and control, and Compliance Order #003 was issued stating the licensee was to ensure that all staff who provided direct care to residents receive annual training on skin and wound care and how to minimize the restraining of residents, both Compliance Order #002 and #003 to be complied with by September 30, 2014.

Review of the home's Infection Prevention and Control (IPC) Mandatory Education Program policy #IPC-EDU-030 reviewed January 2015 stated the IPC Education Program at Lakeland LTC has a Mandatory Component to be reviewed annually by employees including but not limited to: The Chain of Transmission, Routine Practices of Hand Hygiene, and PPEs. The policy failed to identify annual training and retraining for staff in infection prevention and control to include the cleaning and disinfection practices as defined in Regulation 219 (4). Furthermore, upon a review of the 2014 training records it was found that not all staff completed retraining in infection prevention and control practices.

The inspector reviewed the home's New Staff Orientation policy #O.P. 14 issued September 2010 which stated newly hired employees are provided the following supports and education: orientation days, orientation checklist, orientation education day, informal and formal mentoring. The policy further stated that both PSWs and Nursing Managers

are provided six orientation shifts, and that during orientation shifts, new employees will be "buddied" with an experienced staff member and an orientation day will be scheduled twice yearly or more often as required. The orientation day is a formal education session covering the following topics (including but not limited to): Mission/Vision/Values, Codes of Conduct and Lakeland Spirit, Fire Drills and Evacuation, Resident Care/Resident Incidents, Resident Rights/Resident Abuse and Infection Prevention and Control/Isolation.

In an interview with the inspector, s#-109 stated they were hired one month earlier and their first day was shadowing another staff member and they provided resident care. S#-109 further stated they were told they have as long as needed to complete the orientation checklist, and were allowed to ask for more time if needed. When asked by the inspector regarding certain training topics, s#-109 stated they have not been trained on the homes Mission statement, but there were a lot of policies to go through and it may have been in one of those.

The home's training and orientation program fails to comply with the subsection 76 (2) of the Act that stated no person shall perform their responsibilities before receiving training.

The inspector reviewed the home's Minimizing Restraining of Residents: Use of Restraints policy #RSL-SAF-035 effective June 2014 which stated staff who provide direct care to residents must receive annual retraining on restraint policies and procedures and the correct use of equipment as it relates to their jobs, and that staff who provide direct care to residents must receive orientation and annual training on minimizing restraining of residents. According to the same document, orientation and training includes registered staff oriented and trained using on-line training or equivalent on least/minimizing restraints, hands on instruction and practice on correct use of physical restraints using train the trainer methodology and that staff were to review of the Lakeland LTC's restraint policy and procedure "RSL-SAF-035 Minimizing Restraining of Residents: Use of Restraints", and Lakeland LTC's minimizing of restraint program "Least Restraint Program".

During an interview with the inspector, the ADON confirmed "Train-the-Trainer" methodology was used in training staff related to restraint use. Registered staff will train other registered staff and PSWs with hands on instruction and practice on correct use of physical restraints, but registered staff do not sign off on any documentation stating a staff member has received hands on instruction.

In an interview with the inspector, s#-115, stated when they were hired and commenced work they may have had some training on restraints but doesn't feel they had much training. S#-109 stated to the inspector, they had been hired one month earlier and has had no hands on training on restraints but there was information on Surge Learning.

The inspector reviewed the restraint training records from January 01, 2014, up until September 30, 2014 and the following was determined:
- 58/105 staff, or 55% of staff completed Restraints Policy and Procedures
- 65/105 staff, or 62% of staff completed Restraint and PASDs by Surge Learning Video
- 57/105 staff, or 54% of staff completed Least Restraints Program 2014 [s. 8.]

2. During Resident Quality Inspection, #2014_332575_0008, Compliance Order #001 was issued stating the licensee was to ensure that the home's Mantoux Skin Testing policy was complied with by September 30, 2014. In an interview with the inspector, the ADON stated that the home's Mantoux Skin Testing policy had been replaced with the Tuberculin Skin Testing (TST) policy #IPC-SUR-010. The inspector reviewed the home's Tuberculin Skin Testing (TST) policy #IPC-SUR-010 reviewed July 2014 which stated that all residents admitted to Lakeland LTC will:
b.i) have taken a chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility. If the x-ray was not done within the 90 days prior to admission, it should be taken within 14 days of admission. A copy of the x-ray report must be provided to Lakeland LTC.
c) All residents less than 65 years of age, admitted to Lakeland LTC, who are previously skin test negative or unknown, will complete part b above, and complete a 2-step TST initiated within 14 days of admission, unless contraindicated. Note : if resident has a previously documented 2-step TST, only a one step TST is necessary.

The inspector reviewed two residents' health care records admission information, both failed to indicate any TB screening or results.

S#-116 told the inspector that residents are screened for TB by the following procedure: review of the Community Care Access Centre notes for a Chest x-ray in the 90 days prior to admission and if that had not been completed then a requisition for chest x-ray is immediately completed upon admission.

The inspector interviewed the ADON who confirmed that neither of the above residents had TB Screening completed within 14 days of admission. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the Behaviour Restorative Program policy, review date October 2014 was complied with. In a Critical Incident Report submitted to the Director in January 2015, resident #010 was found to have a minor injury, and while the origin of the injuries were not known as stated by the in the report, they may have been caused by the actions of resident #011, or who may have otherwise contributed to the injuries. According to the report submitted to the Director resident #011 had a summary of recent responsive behaviours.

Review of the home's Behaviour Restorative Program policy, stated the goal of the program was to create a resident centered Behaviour Restorative Team to assist those residents who are vulnerable to responsive behaviours. According to the same policy when a resident vulnerable to responsive behaviours is not accommodated or the triggers creating the behaviour are not addressed, any or all aspects of that resident's well being and /or performance will be negatively affected. Inconsistency in approach or expectations, or exposure to specific elements creates distress. The responsibilities of the BRT were to identify and implement care strategies, supports and interventions to prevent or minimize the behavioural response in order to enhance the resident's quality of life and living experience at Lakeland.

A review of the resident's progress notes, by the inspector from date of admission to over the course of two and a half months, identified 16 documented notes stating involvement with the BRT. The inspector reviewed resident #011's care plan which failed to identify any responsive behaviours. In an interview with the inspector, s#-101 stated resident #011 had a history of specific responsive behaviours. S#-101 stated one of the triggers for the resident's responsive behaviours had been identified and should have been identified on the care plan. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 that was used exclusively for drugs. During the course of the inspection, the Inspector observed the following in the Tidy Storage rooms. The tidy storage rooms were observed by the inspector for the use of clean supplies and storage including but not limited to carts containing clean linens, new resident personal care products and clean equipment:

In a specific Tidy Storage room on the counter in a basket:
Voltaren Cream, Rub A535, Nizoral, Anusol-HC, Peridex Oral Rinse

In a specific Tidy Storage room on the counter in a basket:
Clotrimaderm Creamx2, Nizoralx3, Betamethasone Valerate Cream, Betaderm Cream, Valisone Scalp Lotion, Dermarest Psoriasis

During an interview with the Inspector, s#-117 and s#-110 stated that medicated creams are to be kept in the medication room. Both s#-117 and s#-110 told the inspector that registered staff take the basket(s) of medicated creams out of the medication room in the morning for trained staff to access and then returns the basket(s) of medicated creams to the medication room after the morning care is completed. S#-113 told the inspector that creams are locked in the medication room.

The Inspector reviewed the home's Administration, Documentation and Storage Policy #4.8 which stated that all medications are to be stored in a locked medication room, cupboard, or cart. [s. 129. (1) (a) (i)]

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 that is used exclusively for drugs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the following right of residents was fully respected: a resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On Friday March 06, 2015 at 0823 hours the inspector overheard s#-126 yelling for s#-123 while in resident #004's room with the resident's room door open slightly and instructing resident #004 in a loud voice. The inspector observed the RPN walking to resident #004's room and enquiring with s#-126 the cause for yelling for s#-123. S#-126 stated that they couldn't find s#-123 and they required their assistance with the resident. After finishing breakfast resident #004 had been observed participating, in a physiotherapy exercise, by the inspector. At 1005 hours immediately following the physiotherapy exercise, during an interview with the inspector, resident #004 was observed with dried blueberry sauce down the residents chin onto their neck.

Review of resident #004's care plan by the inspector, identified that the resident requires assistance with morning and night care. The inspector interviewed s#-118 who stated that the homes expectations when a resident is leaving the dining room is to have clean hands and a clean face.

The inspector reviewed the home's Meal Time Duties – PSW/HCA policy # RSL-DS-026 which stated a PSW/HCA's responsibilities during mealtime were to clean the resident's hands and face using warm wash clothes provided, before assisting the resident from the dining area. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check must be conducted within six months before a staff member is hired. During an interview with the inspector, the ADON stated that occasionally, in rare circumstances, staff will start performing their duties before a criminal reference check has been obtained because the criminal reference check will be in the process of being completed, and that it takes time.

The inspector requested a Listing of Employees by last Name including start date and randomly selected three staff, an RN, RPN and PSW who had recently been hired. Upon review of the criminal reference checks with s#-119, the inspector identified one of the randomly selected staff members with a criminal reference check dated eight months prior to their hire date. [s. 215. (2) (b)]

Issued on this 24th day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2015_376594_0005
Log No. / Registre no:	S-000279-14, S-000280-14, S-000281-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 3, 2015
Licensee / Titulaire de permis :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LEN FABIANO

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant:
2014_332575_0008, CO #002;
2014_332575_0008, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that no staff member performs their responsibilities before receiving training in the areas mentioned: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff had received training as outlined in this Act before performing their responsibilities and annually thereafter.

During Resident Quality Inspection, 2014_332575_0008, Compliance Order #002 was issued stating the licensee was to ensure that all staff received training, and annual re-training of infection prevention and control, to be complied with by September 30, 2014. A complaint was also received by the Director in January 2015, which stated that there is a lack of training in the home for staff to know what to do and how to care for the residents correctly during an outbreak.

A.Annual Re-training:
The inspector reviewed the Infection Prevention and Control staff training records from January 01, 2014, to September 30, 2014. The training records were compared to the number of staff available, 145 to complete the course, as provided by the DONPC. Training records for hand hygiene, chain of transmission, personal protective equipment (PPE's) and cleaning, as well as disinfection practices were reviewed. It was determined that:
- 0/145 staff, or 0% of staff, completed the Hand Hygiene Policy and Procedure training, but that 43/145 staff, or 30% of staff, completed a hand hygiene demonstration on August 01, 2014;
- 18/145 staff, or 12% of staff, completed the Chain of Transmission Policy and Procedure training;
- 48/145 staff, or 33% of staff, completed the Personal Protective Equipment Policy and Procedure training including a PPE demonstration on August 01, 2014;
- Cleaning and disinfection practices training records were broken down into the following courses:
- Module 2 Routine Practices: 47/145 staff, or 32% of staff
- Module 4a General Cleaning Frequency: 79/145 staff, or 55% of staff
- Module 4b General Cleaning Procedures: 75/145 staff, or 52% of staff
- Module 4c General Cleaning Other considerations: 73/145 staff, or 50% of staff

Review of the home's Infection Prevention and Control (IPC) Mandatory Education Program policy #IPC-EDU-030 reviewed January 2015 stated the IPC Education Program at Lakeland LTC has a Mandatory Component to be

reviewed annually by employees including but not limited to: The Chain of Transmission, Hand Hygiene, and PPEs.

B. Training before performing responsibilities:
The inspector reviewed the home's New Staff Orientation policy #O.P. 14 issued September 2010 which stated newly hired employees are provided the following supports and education: orientation days, orientation checklist, orientation education day, as well as informal and formal mentoring. The policy went on to further state that both PSWs and Nursing Managers are provided six orientation shifts, and that during orientation shifts, new employees will be "buddied" with an experienced staff member and an orientation day will be scheduled twice yearly or more often as required. According to the same policy, the orientation day is a formal education session covering the following topics (including but not limited to): Mission/Vision/Values, Codes of Conduct and Lakeland Spirit, Fire Drills and Evacuation, Resident Care/Resident Incidents, Resident Rights/Resident Abuse and Infection Prevention and Control/Isolation.

In an interview with the inspector, the ADON stated that the orientation process for a new staff hire in the nursing department is as follows: The new staff member's first day at the home is to work with a buddy in a home area observing. During the first day, the new staff member is provided a learning package (SURGE learning) by the Quality Management Coordinator who gives direction on how to access and use SURGE learning, and discusses the time limit to complete all the required orientation learning. On the second day, the new staff member is performing duties, while completing an orientation checklist within a designated period of time. If concerns are identified with the new staff member, the buddy person will report those concerns about the new staff member, to the DONPC and/or ADON.

During an interview with the inspector, the Quality Management Coordinator stated that staff have one month from the day they receive their orientation package (SURGE learning, also referred to as the Day Two package), to complete the package. The Quality Management Coordinator also stated the Orientation Day (Day One/Orientation Education Day) in-service, only occurs a couple times a year. The Quality Management Coordinator provided the inspector with the Annual House wide Training/Day One in-service record for 2014 with the following dates: March 18, 19th and March 25, 26th, 2014.

The inspector reviewed the Day One Orientation Agenda which outlines training

on the home's Mission, Vision and Values, Resident Care – Essential Tools, Resident Safety, Staff Health and Safety, Education and Continual Learning and Professionalism. Review of the Day Two Orientation package by the inspector, states Day Two is an independent participation training day of which the requirement is to complete a number of policy & procedure reviews, quizzes and online learning modules. The inspector reviewed the Day Two Orientation Checklist: Policy and Procedure Review which identifies the following policy and procedures (including but not limited to): Abuse, Infection Prevention & Control Program and Principles of Additional Precautions & Rationale.

In an interview with the inspector, s#-109 stated they were hired one month earlier and their first day was shadowing another staff member and they provided resident care. S#-109 further stated they were told they have as long as needed to complete the orientation checklist, and were allowed to ask for more time if needed. When asked by the inspector regarding certain training topics, s#-109 stated they have not been trained on the homes Mission statement, but there were a lot of policies to go through and it may have been in one of those.

The inspector reviewed s#-127's Day Two Orientation Checklist which stated policy and procedure review completed three months later.

Given that not all staff completed the required annual retraining prior to the compliance order date of September 30, 2014, and that staff performed duties prior to receiving training, the licensee has failed to comply with Compliance Order #002 and to ensure that all staff had received training before performing their responsibilities. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_332575_0008, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Order / Ordre :

The licensee shall ensure that the Infection Prevention and Control Mandatory Education Program and Tuberculin Skin Testing policy, New Staff Orientation procedure, Minimizing Restraining of Residents staff training procedure, Behaviour Restorative Program is complied with, and implemented in accordance with all applicable requirements under the Act and is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that where required, the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the Act.

During Resident Quality Inspection, #2014_332575_0008, Compliance Order #002 was issued stating the licensee was to ensure that all staff received training, and annual re-training of infection prevention and control, and Compliance Order #003 was issued stating the licensee was to ensure that all staff who provided direct care to residents receive annual training on skin and wound care and how to minimize the restraining of residents, both Compliance Order #002 and #003 to be complied with by September 30, 2014.

Review of the home's Infection Prevention and Control (IPC) Mandatory Education Program policy #IPC-EDU-030 reviewed January 2015 stated the IPC Education Program at Lakeland LTC has a Mandatory Component to be reviewed annually by employees including but not limited to: The Chain of Transmission, Routine Practices of Hand Hygiene, and PPEs. The policy failed to identify annual training and retraining for staff in infection prevention and control to include the cleaning and disinfection practices as defined in Regulation 219 (4). Furthermore, upon a review of the 2014 training records it

was found that not all staff completed retraining in infection prevention and control practices.

The inspector reviewed the home's New Staff Orientation policy #O.P. 14 issued September 2010 which stated newly hired employees are provided the following supports and education: orientation days, orientation checklist, orientation education day, informal and formal mentoring. The policy further stated that both PSWs and Nursing Managers are provided six orientation shifts, and that during orientation shifts, new employees will be "buddied" with an experienced staff member and an orientation day will be scheduled twice yearly or more often as required. The orientation day is a formal education session covering the following topics (including but not limited to): Mission/Vision/Values, Codes of Conduct and Lakeland Spirit, Fire Drills and Evacuation, Resident Care/Resident Incidents, Resident Rights/Resident Abuse and Infection Prevention and Control/Isolation.

In an interview with the inspector, s#-109 stated they were hired one month earlier and their first day was shadowing another staff member and they provided resident care. S#-109 further stated they were told they have as long as needed to complete the orientation checklist, and were allowed to ask for more time if needed. When asked by the inspector regarding certain training topics, s#-109 stated they have not been trained on the homes Mission statement, but there were a lot of policies to go through and it may have been in one of those.

The home's training and orientation program fails to comply with the subsection 76 (2) of the Act that stated no person shall perform their responsibilities before receiving training.

The inspector reviewed the home's Minimizing Restraining of Residents: Use of Restraints policy #RSL-SAF-035 effective June 2014 which stated staff who provide direct care to residents must receive annual retraining on restraint policies and procedures and the correct use of equipment as it relates to their jobs, and that staff who provide direct care to residents must receive orientation and annual training on minimizing restraining of residents. According to the same document, orientation and training includes registered staff oriented and trained using on-line training or equivalent on least/minimizing restraints, hands on instruction and practice on correct use of physical restraints using train the trainer methodology and that staff were to review of the Lakeland LTC's restraint

policy and procedure "RSL-SAF-035 Minimizing Restraining of Residents: Use of Restraints", and Lakeland LTC's minimizing of restraint program "Least Restraint Program".

During an interview with the inspector, the ADON confirmed "Train-the-Trainer" methodology was used in training staff related to restraint use. Registered staff will train other registered staff and PSWs with hands on instruction and practice on correct use of physical restraints, but registered staff do not sign off on any documentation stating a staff member has received hands on instruction.

In an interview with the inspector, s#-115, stated when they were hired and commenced work they may have had some training on restraints but doesn't feel they had much training. S#-109 stated to the inspector, they had been hired one month earlier and has had no hands on training on restraints but there was information on Surge Learning.

The inspector reviewed the restraint training records from January 01, 2014, up until September 30, 2014 and the following was determined:
- 58/105 staff, or 55% of staff completed Restraints Policy and Procedures
- 65/105 staff, or 62% of staff completed Restraint and PASDs by Surge Learning Video
- 57/105 staff, or 54% of staff completed Least Restraints Program 2014 (594)

2. The licensee has failed to ensure that the Behaviour Restorative Program policy, review date October 2014 was complied with. In a Critical Incident Report submitted to the Director during January 2015, resident #010 was found to have a minor injury, and while the origin of the injuries were not known as stated by the in the report, they may have been caused by the actions of resident #011, or who may have otherwise contributed to the injuries. According to the report submitted to the Director resident #011's summary of recent responsive behaviours.

Review of the home's Behaviour Restorative Program policy, stated the goal of the program was to create a resident centred Behaviour Restorative Team to assist those residents who are vulnerable to responsive behaviours. According to the same policy when a resident vulnerable to responsive behaviours is not accommodated or the triggers creating the behaviour are not addressed, any or all aspects of that resident's well being and /or performance will be negatively affected. Inconsistency in approach or expectations, or exposure to specific

elements creates distress. The responsibilities of the BRT were to identify and implement care strategies, supports and interventions to prevent or minimize the behavioural response in order to enhance the resident's quality of life and living experience at Lakeland.

A review of the resident's progress notes, by the inspector from date of admission to over the course of two and a half months, identified 16 documented notes stating involvement with the BRT. The inspector reviewed resident #011's care plan which failed to identify any responsive behaviours. In an interview with the inspector, s#-101 stated resident #011 had a history of specific responsive behaviours. S#-101 stated one of the triggers for the resident's responsive behaviours had been identified and should have been identified on the care plan. (594)

3. During Resident Quality Inspection, #2014_332575_0008, Compliance Order #001 was issued stating the licensee was to ensure that the home's Mantoux Skin Testing policy was complied with by September 30, 2014. In an interview with the inspector, the ADON stated that the home's Mantoux Skin Testing policy had been replaced with the Tuberculin Skin Testing (TST) policy #IPC-SUR-010. The inspector reviewed the home's Tuberculin Skin Testing (TST) policy #IPC-SUR-010 reviewed July 2014 which stated that all residents admitted to Lakeland LTC will:
b.i) have a chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility. If the x-ray was not done within the 90 days prior to admission, it should be taken within 14 days of admission. A copy of the x-ray report must be provided to Lakeland LTC.
c) All residents less than 65 years of age, admitted to Lakeland LTC, who are previously skin test negative or unknown, will complete part b above, and complete a 2-step TST initiated within 14 days of admission, unless contraindicated. Note : if resident has a previously documented 2-step TST, only a one step TST is necessary.

The inspector reviewed two residents' health care record with an admission information, both failed to indicate any TB screening or results.

S#-116 told the inspector that residents are screened for TB by the following procedure: review of the Community Care Access Centre notes for a Chest x-ray in the 90 days prior to admission and if that had not been completed then a requisition for chest x-ray is immediately completed upon admission.

The inspector interviewed the ADON who confirmed that neither of the above residents had TB Screening completed within 14 days of admission. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff receive retraining annually on the home's policy to promote zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff receive retraining annually on the home's policy to promote zero tolerance of abuse and neglect of residents. In an interview with the inspector, s#-106 stated they had been trained on the home's policy to promote zero tolerance of abuse but was not sure when that last occurred. The inspector reviewed the training records for the home's policy to promote zero tolerance of abuse and neglect of residents for the period of January 01, 2014 to December 31, 2014, and found that 10 of 143, or 7% of staff completed training on the home's policy to promote zero tolerance of abuse and neglect of residents. (594)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that all staff who provide direct care to residents receive training and retraining at the times or intervals provided for in the regulations in minimize the restraining of residents and skin and wound care.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff who provided direct care to residents, received training in the restraining of residents and in other areas provided for in the regulations such as skin and wound care. During Resident Quality Inspection, 2014_332575_0008, Compliance Order #003 was issued stating the licensee was to ensure that all staff who provided direct care to residents receive annual training on skin and wound care and how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

In an interview with the inspector, s#-115, stated when they were hired they may have had some training on restraints but doesn't feel they had much training. S#-109 stated to the inspector, they had been hired one month earlier and has had no hands on training on restraints but there was information on Surge Learning.

The inspector reviewed the home's Minimizing Restraining of Residents: Use of Restraints policy #RSL-SAF-035 effective June 2014, which stated staff who provide direct care to residents must receive annual retraining on restraint policies and procedures and the correct use of equipment as it relates to their jobs. Staff who provide direct care to residents must receive orientation and annual training on minimizing restraining of residents. According to the same document, orientation and training includes registered staff oriented and trained using on-line training or equivalent on least/minimizing restraints, hands on instruction and practice on correct use of physical restraints using "Train-the-Trainer" methodology. Staff were also required to review Lakeland LTC's restraint policy and procedure "RSL-SAF-035 Minimizing Restraining of Residents: Use of Restraints", and Lakeland LTC's minimizing of restraint program "Least Restraint Program".

During an interview with the inspector, the ADON confirmed "Train-the-Trainer" methodology was used in training staff related to restraint use. Registered staff will train other registered staff and PSWs with hands on instruction and practice on correct use of physical restraints, but registered staff do not sign off on any documentation stating a staff member has received hands on instruction.

The inspector reviewed the skin and wound care as well as restraint staff training records from January 01, 2014, up until September 30, 2014. The training records were compared to the number of direct care staff available, 105 staff members were required to complete the training. The following was determined:
- 38/105 staff, or 36% of staff completed Skin and Wound Care Program training

Restraint training records were broken down into the following courses:
- 58/105 staff, or 55% of staff completed Restraints Policy and Procedures
- 65/105 staff, or 62% of staff completed Restraint and PASDs by Surge Learning Video
- 57/105 staff, or 54% of staff completed Least Restraints Program 2014 (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 3rd day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Monika Gray

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