Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2017	2017_414110_0012	023803-17	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

DIANE BROWN (110), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31 and November 1, 2017

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Registered Nurses (RN), Registered Dietitian (RD), Director of Dietary Services (DDS), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Cook, President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

Resident #003 triggered during stage one related to an eating decline.

Resident #003 was observed at lunch on an identified date. Staff, PSW #107 was observed offering resident #003 “apple, orange or cranberry juice”, and one, 125ml glass of juice was served . Interview with the PSW confirmed that only juice was offered.

Review of resident #003’s progress notes identified documentation that on four separate occasions the resident was not meeting his/her minimum fluid servings for the past 3 days.

Record review of the home’s therapeutic menu for lunch identified 125ml milk, 180ml water and 180ml coffee or tea.

Interview with PSW #109 revealed that there was no required beverage standard served at mealtimes. PSW’s #110 and #111 revealed that residents are served one drink, usually juice, plus tea and coffee.

Interview with the RD during meal service, confirmed through observation with inspector that the beverages served had not been provided according to the menu and identified that what was offered and served to residents was well below the home’s menu standard.

2. Resident #006 triggered during stage one related to a low Body Mass Index, (BMI) with no plan.

Record review of resident’s written plan of care, identified resident #006 at nutritional risk. The resident was identified as requiring a texture modified diet with an individualized nutrition intervention. Resident’s nutrition goal included having resident maintain his/her weight.

Record review of the resident’s Weight Summary Report revealed resident's current monthly weight was down from the previous month.

Review of resident #006’s progress notes revealed documentation that on six separate occasions resident #006 was not meeting his/her minimum fluid servings for the past 24 hr to three days.

Resident #006 was observed at a breakfast meal on an identified date. Resident was observed being offered beverages and food. The resident's meal was confirmed by staff

#112 who assisted resident with his/her meal.

Record review of the home's therapeutic menu for the identified breakfast revealed 125ml juice, 250ml milk, 180ml water and 180ml coffee or tea as the fluids to be offered and served. All four beverages were not offered.

Record review of the home's breakfast menu identified foods to be offered.

Interview with dietary aide #116, serving the identified meal, confirmed that all menu breakfast items were not available according to the menu.

Interview with cook #118 and DDS confirmed that all breakfast menu items had not been prepared for resident #006's texture modified diet.

PSW #117 who was assisting another resident with the same diet type as resident #006, confirmed that the identified menu items were not available and seldom available. A review of the home's breakfast menu of two days prior, identified the same menu items. Staff, PSW #109 confirmed that these identified menu items had not been available at the meal, on that day, as well.

Resident #006 was observed at a lunch meal on an identified day. Resident was served 125ml glass of chocolate milk which was confirmed by PSW #112.

Record review of the home's therapeutic menu for the lunch meal included 180ml soup, 125ml milk, 180ml water and 180ml coffee or tea. Soup, water and coffee/tea were not offered to resident #006.

Resident #006 was observed at supper meal. Resident was served 125ml glass of apple juice and 125ml coffee. Interview with PSW #110 confirmed that she offered resident "apple, orange, cranberry or tomato juice" and that resident #006 said yes to apple. Staff confirmed that he/she did not offer the resident milk.

Record review of the home's therapeutic menu for supper identified 125ml milk, 125ml tomato juice, 180ml water and 180ml coffee or tea.

Resident interview identified he/she felt hungry after supper and could eat more at meals. He/she further stated that he/she liked milk and coffee to drink.

Interview with the RD and DDS confirmed that the home's menu had not been followed with respect to offering the full meal and all beverages.

3. Resident #007 triggered during stage one related to a low BMI with no plan.

Record review of resident #007 identified resident's diet order.

Resident #007 was observed at breakfast on an identified date. A review of the menu for the breakfast meal revealed menu items not available or offered to resident #007. Staff #117 confirmed they were not available or offered.

A review of the home's breakfast menu of two days prior, identified the same menu items. An interview with PSW #109, who had served breakfast on this date, confirmed that the identified items were not available at the meal, on that day, as well.

Resident #007 was observed at lunch on an identified date. Resident was offered and served 125ml tomato juice. PSW #107 confirmed that one glass of beverage was offered.

Record review of the home's therapeutic menu for lunch identified 125ml milk, 180ml water and 180ml coffee or tea to be offered.

Interview with the RD and DDS confirmed that the home's menu had not been followed with respect to offering the full meal and offering of all beverages.

The severity of the non-compliance was potential for or actual harm/risk.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non compliances in the last three years.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure they have fully respected and promoted the resident's right to be treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity.

During stage one of the Resident Quality Inspection (RQI) a resident interview identified how PSW #112's interaction towards another identified resident, #009, had been disrespectful.

Interview RPN #119 revealed that if staff interacted with resident #009 in the identified manner it would not be appropriate or well received by the resident.

Interview with staff #112 revealed that he/she had witnessed staff #109 interact with resident #009 in the identified manner and confirmed that he/she had also interacted in the same manner. Staff #112 revealed that it was not appropriate now that he/she had been asked about it.

Interview with PSW #117 revealed that staff #109 can interact with resident #009 in an identified manner and that he/she felt that resident #009 did not like it. Staff #117 stated that staff #109 meant to be funny to resident #009 but that resident #009's reaction told him/her that he/she does not like the manner in which staff #109 interacted with him/her.

Interview with PSW #109 revealed that he/she had interacted with resident #009 in an identified manner and did not intend to be disrespectful.

Interview with the DOC revealed that he/she would not interact with resident #009 in the identified manner. He/she stated that he/she heard staff refer to the home as a family but revealed what may be appropriate to say to a family member would not necessarily be appropriate to say to a resident and it was the resident's home.

The DOC acknowledged that interacting with resident #009 in the identified manner would not promote resident's right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. During stage one of the RQI a resident interview revealed an incident with another resident and described how a staff, PSW #121 reacted to him/her at the time of the incident. The identified resident interviewed did not feel he/she was respected by staff PSW #121.

Record review of the resident's health record identified a progress note on an identified date documented by staff #119, which coincided with the incident described by the resident during the resident interview.

Interview with registered staff #119 confirmed the incident and that PSW #121's interaction with the resident had not been respectful.

The DOC acknowledged the manner in which staff #121 interacted with the identified resident was not a respectful.

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 they have fully respected and promoted the resident's right to be treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A medication pass observation was conducted on an identified date for resident #008. RN #100 was observed and confirmed the administration of an identified medication to resident #008 as was indicated on the electronic Medication Administration Record (eMAR) screen.

A review of resident #008's most recent physician orders and the three month medication review in place at the time of the medication pass observations was completed . A review of resident #008's subsequent eMAR was also noted and was not consistent with the physician orders and three month medication review.

Interview with RN #100 stated that the resident's written plan of care included the eMAR. The RN further acknowledged that resident #008's written plan of care did not provide clear directions in keeping with the physician's order on administering the identified medication.

Interview with the DOC revealed he/she investigated the above mentioned discrepancy following the medication pass observation. He/she further acknowledged that the resident's written plan of care did not provide clear directions to staff in regards to the dosage of the identified medication to be administered. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During stage one of the RQI, resident #006 was triggered related to potential side rail restraint.

Observations conducted by inspectors #110 and #653 on identified dates revealed side rails in the up position on resident #006's bed.

Review of resident #006's Resident Assessment Instrument-Minimum Data Set (RAI-

MDS) assessment, revealed he/she was totally dependent on two staff for bed mobility. Review of resident #006’s current written plan of care indicated he/she used two rails when in bed and required weight bearing assistance by two staff for bed mobility.

The inspector attempted to interview resident #006, however, he/ she had a Cognitive Performance Scale (CPS) score which equated to moderate cognitive impairment. The resident was not interviewable.

Interviews with Personal Support Worker (PSW) #101 and Registered Nurse (RN) #105 revealed that the resident had no longer been using the side rails for bed mobility. Both staff further indicated that the resident was incapable of holding on to the side rails when turning and repositioning in bed, and that he/she was dependent on two staff for bed mobility. RN #105 stated that the process in the home was for the Physiotherapist (PT) to assess each resident to identify their need for side rail use.

Review of a progress note on an identified date, revealed the last assessment note by the PT indicated that the resident had been seen for a bed mobility assessment and use of side rails, and that he/she was able to turn to the right with the help of the side rails. Resident #006 needed both side rails for bed mobility and transfers.

There were no further records obtained to indicate that a re-assessment had been completed for the resident following the above mentioned assessment.

Review of a progress note on an identified date, revealed that a referral had been sent by the DOC to the PT, requesting an assessment for bed rails as there had been a change in the resident's bed mobility on days and the need for bed rails to assist in bed mobility.

Interview with the DOC, acknowledged the above mentioned information, and that the home’s expectation was for the PSW to inform the nurse of his/her observation, so that the nurse can put in a referral to the PT for re-assessment of resident #006’s side rail use. [s. 6. (4) (a)]

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

During stage one of the Resident Quality Inspection (RQI), resident #006 was triggered related to potential side rail restraint.

Observations conducted by inspectors #110 and #653 on identified dates revealed side rails in the up position on resident #006's bed.

Review of resident #006’s current written plan of care indicated he/she used two rails when in bed and required weight bearing assistance by two staff for bed mobility.

The inspector attempted to interview resident #006, however, he/ she had a Cognitive Performance Scale (CPS) score which equated to moderate cognitive impairment. The resident was not interviewable.

Interviews with Personal Support Worker (PSW) #101 and Registered Nurse (RN) #105 revealed that the resident had no longer been using the side rails for bed mobility. Both staff further indicated that the resident was incapable of holding on to the side rails when turning and repositioning in bed, and that he/she was dependent on two staff for bed mobility. RN #105 acknowledged that the resident had not been re-assessed and his/her written plan of care had not been reviewed and revised when his/her care needs changed in regards to side rail use.

Interview with the Director of Care (DOC), acknowledged the above mentioned information, and that the home’s expectation was for the resident to be re-assessed and the written plan of care revised when there was a change in the resident's care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 114 (2), (3) a, The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of Medical Pharmacies' policy titled "Individual Monitored Medication Record" policy #6-5 dated February 2017, indicated the following under procedure: "Sign on the 'Individual Monitored Medication Record' each time a dose is administered. Include the date, time, amount given, amount wasted, and new quantity remaining".

On an identified date, at 1415 hrs, inspector #653 and RN #100 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication.

Upon review, the inspector and the RN noted that resident #011's narcotic blister pack had 19 remaining narcotic tablets while the individual monitored medication record indicated that 20 tablets were left. Further review of the document revealed that the last documentation of administration was three days prior to the narcotic count.

Review of resident #011's progress note one day prior to the narcotic count revealed he/she was given the identified narcotic tablet at 1953 hrs with good effect.

Interview with the DOC acknowledged the above mentioned discrepancy and that the home's policy had not been complied with. [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 any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident’s health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including height, weight and any risks related to nutrition care, and assess hydration status, and any risks related to hydration.

Resident #006 triggered during stage one related to a low BMI (Body Mass Index) and no plan.

Record review of resident’s written plan of care, identified resident #006 at nutritional risk. The resident was identified as requiring a texture modified diet with an individualized nutrition intervention. Resident’s nutrition goal included having resident maintain his/her weight.

Record review of the resident’s Weight Summary Report revealed resident's monthly

weight was down from the previous month.

Review of resident #006's progress notes revealed documentation that on six separate occasions resident #006 was not meeting his/her minimum fluid servings for the past 24 hr to three days.

Resident interview identified that he/she does feel hungry after dinner and that he/she could eat more at meals. Resident revealed that he/she liked both milk and coffee.

Resident #006 was observed at a breakfast meal on an identified date. Resident was observed being offered beverages and food. The resident's meal was confirmed by staff #112 who assisted resident with his/her meal.

Record review of the home's therapeutic menu for the identified breakfast revealed 125ml juice, 250ml milk, 180ml water and 180ml coffee or tea as the fluids to be offered and served. All four beverages were not offered.

Record review of the home's menu identified foods to be offered.

Interview with dietary aide #116, serving the identified meal, confirmed that all menu items were not available according to the menu.

Interview with cook #118 and DDS confirmed that all breakfast menu items had not been prepared for resident #006's texture modified diet.

PSW #117 who was assisting another resident with the same diet type as resident #006, confirmed that the identified menu items were not available and seldom available. A review of the home's breakfast menu of two days prior, identified the same menu items. Staff, PSW #109 confirmed that these identified menu items had not been available at the meal, on that day, as well.

Resident #006 was observed at a lunch meal on an identified day. Resident was served 125ml glass of chocolate milk and confirmed by PSW #112.

Record review of the home's therapeutic menu for this identified meal included 180ml soup, 125ml milk, 180ml water and 180ml coffee or tea. Soup, water and coffee/tea were not offered to resident #006.

Resident #006 was observed at supper meal. Resident was served 125ml glass of apple juice and 125ml coffee. Interview with PSW #110 confirmed that she offered resident "apple, orange, cranberry or tomato juice" and that resident #006 said yes to apple. Staff confirmed that he/she did not offer the resident milk.

Record review of the home's therapeutic menu for supper identified 125ml milk, 125ml tomato juice, 180ml water and 180ml coffee or tea.

Record review of the home's menu and interview with RD identified that each resident is offered a minimum standard of daily fluids including 250ml milk, 180ml water and 125ml juice plus coffee/ tea at breakfast; 125ml milk and 180ml water, plus coffee/ tea at lunch and 125ml milk, 125 tomato juice, 180ml water and coffee/tea at dinner. Interview further revealed that the home's texture modified menu should be fully prepared and offered to residents requiring that diet.

Interview with the RD revealed he/she was unaware that resident #001 was not served juice, milk, water, coffee/ tea at meals in accordance to the planned menu and that access to the menus standard for fluids was not provided. The RD was unaware that soup was not always offered to resident #006 or a full texture modified breakfast meal according to the menu.

The RD identified that these missing components at resident #006's meal were not assessed and could place the resident at nutrition/hydration risk. [s. 26. (4) (a),s. 26. (4) (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 the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including height, weight and any risks related to nutrition care, and assess hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration.

Mealtime observations and staff interviews identified that the full breakfast meal in keeping with the planned menu was not available or offered to residents on minced and pureed diets. Meal observations further identified that fluids were not offered to residents in keeping with the therapeutic menu and home’s policy "Hydration Program" #XI-G-20.20 revised date of July 2015.

An interview with the DDS identified that staff were not offering beverages according to the menu and not acknowledging glass size for volume of fluid offered were risks that could impact residents receiving adequate fluids. The DDS further confirmed that not providing a full meal according to the menu was a risk that could also impact residents not receiving adequate nutrition.

The DSS confirmed that the nutrition care and hydration program failed to identify these risks, by way of auditing adherence to the menu and staff education. [s. 68. (2) (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 the nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A medication pass observation was conducted on an identified date and time for resident #008. RN #100 checked the resident and administered the medication. Interview with the RN confirmed he/she administered the medication to the resident, as was indicated on the electronic Medication Administration Record (eMAR) screen.

Review of resident #008’s most recent physician orders and the three month medication review dated in place prior to the medication pass observation, indicated the order for the medication.

Review of resident #008’s October 2017, eMAR was completed and was not consistent with the physician orders and the three month medication review.

Interview with the RN confirmed he/she did not administer the drug to resident #008 as prescribed.

Interview with the DOC revealed he/she investigated on the above mentioned discrepancy following the medication pass observation. He/she further acknowledged that the medication was not administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. On an identified date and time inspector #653 and RN #100 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication.

Upon review, the RN and the inspector noted that resident #010’s narcotic blister pack had 10 remaining narcotic capsules while the individual monitored medication record indicated that 9 capsules were left. RN #100 confirmed he/she forgot to administer the 0800 hrs narcotic to the resident, but signed that the narcotic was given. The RN further acknowledged that he/she did not administer the drug to resident #010 as prescribed.

Interview with the DOC acknowledged the above mentioned information and that the narcotic drug was not administered to resident #010 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident's attending physician or the registered nurse in the extended class attending the resident.

As part of the RQI, the home's medication incidents within the last three months from the first date of the inspection had been reviewed.

Review of Medical Pharmacies' policy titled "Medication Incident Reporting" policy #9-1 dated February 2017, indicated the following under procedure: "Every medication incident and adverse drug reaction involving a resident (excluding near miss) is to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/ Clinical Consultant Pharmacist".

Interview with RN #100 stated that when a medication incident occurred, the registered staff would notify the resident, their family, the doctor, pharmacy, the DOC, and fill out the medication incident report.

A review of the medication incident indicated that on an identified date, resident #008 received additional dosage of a prescribed medication. Review of the report and progress notes did not identify any documentation indicating that the attending physician had been notified of the medication incident.

Interview with the DOC acknowledged that the attending physician had not been notified of the above mentioned medication incident, and that the home's expectation was for the physician to be notified of the medication incident as required. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident's attending physician or the registered nurse in the extended class attending the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided to Residents' Council in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Residents' Council meeting minutes of September 19, 2017 identified the following two concerns:
Residents in semi-private rooms would like to know why they cannot have their doors closed at nights.
Residents request that the windows be washed, stating that half of the long term care was washed and the other half was missed.

Interview with the President of Residents' Council on October 25, 2017, identified that the Council does not receive a written response within 10 days and that the home follows up at the next meeting. The President confirmed that no response was yet received to the concerns addressed at the September 19, 2017 Residents' Council meeting.

The DOC acknowledged that if the President stated that a response had not been provided that he/she would be correct. The DOC was unable to demonstrate that a written response was provided to Residents' Council in follow up to the concerns expressed at the September 19, 2017, Residents' Council meeting. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure they consult regularly with the Residents' Council, and in any case, at least every three months.

Record review of the last six Residents' Council meeting minutes; September 19, 2017, June 13, 2017, March 21, 2017, January 17, 2017, November 22, 2016 and September 27, 2016 and an interview with the President of Residents' Council failed to confirm the licensee or delegate consulted regularly, and in any case, at least every three months.

The DOC was unable to confirm that the licensee consulted regularly with the Residents' Council, and in any case, at least every three months. [s. 67.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure the required information for the purposes of subsections (1) and (2), copies of the inspection reports from the past two years for the long-term care home are posted in the home..

On October 17, 2017, at 0917 hrs, during the initial tour day one of the RQI a review of the posted inspection reports was completed. One inspection report # 2017-491647-0002, dated February 21, 2017 was observed to be posted.

The DOC confirmed that only one report was posted and that inspection report # 2016_440210_0006 dated April 27, 2016 was not posted in the home. [s. 79. (3) (k)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Record review of the last six Residents' Council meeting minutes and interview with the President of Resident Council failed to confirm that the home seeks the advice of the Residents' Council, if any, in acting on the results of the satisfaction survey.

Interview with the DOC confirmed that that Residents' Council was not asked for advice in acting on the results of the satisfaction survey in 2016. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

Record review of the last six Residents' Council meeting minutes; September 19, 2017, June 13, 2017, March 21, 2017 January 17, 2017, November 22, 2016 and September 27, 2016 and an interview with the President of Residents' Council failed to confirm that the licensee communicated that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and good provided to the residents are communicated to the Residents' Council.

Interview with the DOC confirmed that there was no documentation in the Residents' Council meeting minutes to suggest the licensee communicated quality improvements to accommodations, care, services, programs, and goods provided to the residents to the Residents' Council. [s. 228. 3.]

Issued on this 14th day of December, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DIANE BROWN (110), ROMELA VILLASPIR (653)

Inspection No. / No de l'inspection : 2017_414110_0012

Log No. / No de registre : 023803-17

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

Report Date(s) / Date(s) du Rapport : Nov 22, 2017

Licensee / Titulaire de permis : SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

LTC Home / Foyer de SLD : Cedarvale Lodge Retirement and Care Community
121 Morton Avenue, Keswick, ON, L4P-2M5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Fiorinta Flammia

---

To SPECIALTY CARE INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

Upon receipt of this order the following will be initiated:

1. Education shall be provided to all PSW staff on the components of a meal required to be offered to residents including texture modified foods and beverages.
2. A record of staff attendance at the training shall be available upon inspectors request.
3. Education to all cooks and dietary aides on the responsibilities to prepare the planned menu for meals and snacks.
4. A record of staff attendance shall be available upon inspectors request. Record should be signed by staff attending the training.
5. Posting of the menu to include texture modified diets.
6. An audit to be developed and implemented for one menu cycle to ensure compliance to offering the planned menu.

Grounds / Motifs :

1. Resident #007 triggered during stage one related to a low BMI with no plan.

Record review of resident #007 identified resident's diet order.

Resident #007 was observed at breakfast on an identified date. A review of the menu for the breakfast meal revealed menu items not available or offered to resident #007. Staff #117 confirmed they were not available or offered.

A review of the home's breakfast menu of two days prior, identified the same menu items. An interview with PSW #109, who had served breakfast on this date, confirmed that the identified items were not available at the meal, on that day, as well.

Resident #007 was observed at lunch on an identified date. Resident was offered and served 125ml tomato juice. PSW #107 confirmed that one glass of beverage was offered.

Record review of the home's therapeutic menu for lunch identified 125ml milk, 180ml water and 180ml coffee or tea to be offered.

Interview with the RD and DDS confirmed that the home's menu had not been followed with respect to offering the full meal and offering of all beverages.

The severity of the non-compliance was potential for or actual harm/risk.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non compliances in the last three years.

(110)

2. Resident #006 triggered during stage one related to a low Body Mass Index, (BMI) with no plan.

Record review of resident's written plan of care, identified resident #006 at nutritional risk. The resident was identified as requiring a texture modified diet with an individualized nutrition intervention. Resident's nutrition goal included having resident maintain his/her weight.

Record review of the resident's Weight Summary Report revealed resident's current monthly weight was down from the previous month.

Review of resident #006's progress notes revealed documentation that on six separate occasions resident #006 was not meeting his/her minimum fluid servings for the past 24 hr to three days.

Resident #006 was observed at a breakfast meal on an identified date. Resident was observed being offered beverages and food. The resident's meal was confirmed by staff #112 who assisted resident with his/her meal.

Record review of the home's therapeutic menu for the identified breakfast revealed 125ml juice, 250ml milk, 180ml water and 180ml coffee or tea as the fluids to be offered and served. All four beverages were not offered.

Record review of the home's breakfast menu identified foods to be offered.

Interview with dietary aide #116, serving the identified meal, confirmed that all menu breakfast items were not available according to the menu.

Interview with cook #118 and DDS confirmed that all breakfast menu items had not been prepared for resident #006's texture modified diet.

PSW #117 who was assisting another resident with the same diet type as resident #006, confirmed that the identified menu items were not available and seldom available. A review of the home's breakfast menu of two days prior, identified the same menu items. Staff, PSW #109 confirmed that these identified menu items had not been available at the meal, on that day, as well.

Resident #006 was observed at a lunch meal on an identified day. Resident was served 125ml glass of chocolate milk which was confirmed by PSW #112.

Record review of the home's therapeutic menu for the lunch meal included 180ml soup, 125ml milk, 180ml water and 180ml coffee or tea. Soup, water and coffee/tea were not offered to resident #006.

Resident #006 was observed at supper meal. Resident was served 125ml glass of apple juice and 125ml coffee. Interview with PSW #110 confirmed that she offered resident "apple, orange, cranberry or tomato juice" and that resident #006 said yes to apple. Staff confirmed that he/she did not offer the resident milk.

Record review of the home's therapeutic menu for supper identified 125ml milk, 125ml tomato juice, 180ml water and 180ml coffee or tea.

Resident interview identified he/she felt hungry after supper and could eat more at meals. He/she further stated that he/she liked milk and coffee to drink.

Interview with the RD and DDS confirmed that the home's menu had not been followed with respect to offering the full meal and all beverages.

(110)

3. Resident #007 triggered during stage one related to a low BMI with no plan.

Record review of resident #007 identified resident's diet order.

Resident #007 was observed at breakfast on an identified date. A review of the menu for the breakfast meal revealed menu items not available or offered to resident #007. Staff #117 confirmed they were not available or offered.

A review of the home’s breakfast menu of two days prior, identified the same menu items. An interview with PSW #109, who had served breakfast on this date, confirmed that the identified items were not available at the meal, on that day, as well.

Resident #007 was observed at lunch on an identified date. Resident was offered and served 125ml tomato juice. PSW #107 confirmed that one glass of beverage was offered.

Record review of the home’s therapeutic menu for lunch identified 125ml milk, 180ml water and 180ml coffee or tea to be offered.

Interview with the RD and DDS confirmed that the home’s menu had not been followed with respect to offering the full meal and offering of all beverages.

The severity of the non-compliance was potential for or actual harm/risk.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non compliances in the last three years.
.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 22nd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DIANE BROWN

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