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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2014	2014_267528_0027	H-001076-14	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

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

CEDARWOOD VILLAGE
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

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

CYNTHIA DITOMASSO (528), CAROL POLCZ (156), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 11, 12, 13, 14, 15, 18, 19, 20, 21, 2014

This inspection was done concurrently with Critical Incident Systems Inspection Log# H-000632-14, and Complaint Inspection Log#'s H-000769-14 and H-000863-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Food Services Manager/Housekeeping Manager(FSM), Environmental Services Manager (ESM), Registered Nurse (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides, housekeeping, recreational therapists, Staffing Coordinator, resident and families

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and the complaints log

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that daily and weekly menus were communicated to residents.

A) On one day of the inspection, the weekly menu was not communicated to the residents and on three days of the inspection, the daily menus were not communicated to the residents.

i. On August 12, 2014, the posted weekly menu outside of dining room #2 was for week #3 which did not match the daily menu for week #2 on the white board. The

weekly menu was not communicated to the residents.
ii. On Aug 14, 2014 it was noted that the posted daily menu on the white board outside of dining room #2 was still from the day before and had not been changed to inform residents of the daily menu.
iii. On August 19, 2014, the daily menu was not posted on white board outside of dining room #2
iv. On August 20, 2014, the daily menu was not posted on white board outside of dining room #2.

Registered staff confirmed the weekly and daily menus were not communicated to the residents, as indicated above. [s. 73. (1) 1.]

2. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

Review of Residents' Council Meeting Minutes for the past 14 months and interviews with the Council President and Assistant confirmed that the Council did not review the meal and snack times as part of the dining and snack service. [s. 73. (1) 2.]

3. The licensee has failed to ensure that food and fluids were served at a temperature that were both safe and palatable to the residents.

Food temperatures were not found to be in a safe and palatable range. The temperature range in which food-borne bacteria can grow, known as the danger zone is 4 to 60 degrees Celsius (°C) (40 to 140 degrees Farenheit(°F)). A poster found in the home on the third floor dining area on May 23, 2014 indicated the holding temperatures for cold items must be at 4°C and hot food items must be 74°C prior to service.

A) Food temperatures have been reported as an ongoing concern in the home

i. On August 11 and 12, 2014, seven residents expressed concerns regarding food temperatures affecting all meals.
ii. According to the minutes of the Resident Council Food Committee, the residents had reported the food temperatures being too cold at seven out of nine meetings since August 2013.

B) During the lunch meal on August 13, 2014, foods were probed at the following

temperatures:

i. the submarine sandwich at 8.6 degrees Celsius
ii. the puree sub was 5.3 degrees Celsius
iii. puree bread was 11.7 degrees Celsius
iv. puree coleslaw was 7.8 degrees Celsius

C) During the lunch meal on August 14, 2014, foods were probed at the following temperatures:

i. potato salad was 5.5 degrees Celsius
ii. minced potato salad was 5.8 degrees Celsius
iii. puree potato salad was 9.0 degrees Celsius
iv. the sandwich was 10.2 degrees Celsius
v. minced sandwich was 15.7 degrees Celsius
vi. puree sandwich was 31.1 degrees Celsius

D) During the evening meal on August 15, 2014, foods were probed in dining room #1 at the following temperatures:

i. fish entree was 47.4 degrees Celsius
ii. peas were 46.1 degrees Celsius
iii. carrots were 54.4 degrees Celsius
iv. Resident #52 verbalized a concern of being served "stone cold" fish at 17:28 hours, at the completion of eating the entree.
v. Dietary staff confirmed that the entree items were not at the desired temperatures and identified that the serving of the meal was slow due to the staffing complement of the nursing staff on the identified shift.

E) During the lunch meal on August 19, 2014, foods were probed at the following temperatures:

i. Pureed peas were probed at 56.1C
ii. puree meat pie at 52.8C
iii. gravy at 55.6C
iv. minced salad at 8.6C
v. puree salad was probed at 10.5C
vi. puree bread at 10.1C . [s. 73. (1) 6.]

4. The licensee did not ensure that staff members assisted only one or two residents at the same time who needed total assistance with eating or drinking.

During the evening meal in dining room #1 on August 15, 2014, staff were observed to feed three residents at the same time.

i. A PSW was observed initially feeding residents #11 and #51. A third resident at the table, resident #50, was not eating; despite verbal encouragement of staff. Before residents #11 and #50 were completed their entrees, the PSW began assisting resident #50, using physical encouragement and total feeding. The PSW continued to feed all three residents for the remainder of the main course.
ii. It was identified through staff interviews and review of plans of care that residents #11 and #51 required total assistance, and resident #50 required extensive assistance.
iii. Interview with nursing staff at the completion of the meal confirmed that there were usually two staff assigned to assist the three residents at the table with eating; however, due to the staffing complement on the specified shift only one was available to provide the assistance required, and that assistance was provided to more than two residents at the same time. [s. 73. (2) (a)]

5. The licensee did not ensure that all residents who required assistance with eating or drinking were served a meal only when someone was available to provide the assistance.

During the evening meal in dining room #1 on August 15, 2014, not all residents were served their meal before someone was available to provide assistance to them as required.

i. Residents #11 and #51, who required total feeding, were served their main entree at 17:16 hours; however, staff were not available to provide assistance until 17:21 hours.
ii. Resident #51 was served dessert at 17:47 hours; however, did not receive assistance with feeding until 17:55 hours.
iii. Resident #50 who required extensive assistance with eating was served their main entree at 17:16 hours; however, staff did not provide assistance, which included feeding until 17:24 hours. [s. 73. (2) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A). Three residents interviewed on August 11 and 12, 2014, answered "no" when asked if the staff treated them with respect and dignity.

B) The plan of care for resident #17 indicated the resident had both hearing and sight loss, requiring the assistance of staff for activities of daily living.

i. Documented statements about the resident noted in the progress notes from March to July 2014, did not indicate that the resident was treated with courtesy and respect. Statements about the resident included "very needy", "miserable", "very cranky", "needy and making a fuss".
ii. Interview with two registered staff confirmed that the wording choices of statements listed above should not have been used.

C) On August 15, 2014 at 0850 hours, Inspector #528 overheard resident #47 indicate to staff that they were having difficulty breathing, to which the PSW said "You can breathe just fine..", and escorted the resident to the dining room.

i. Review of the plan of care for the resident revealed that the resident had a diagnosis of respiratory disease with symptoms of shortness of breath. Interventions included continuous oxygen and the administration of inhalers and anti-anxiety medication both routinely, as well as additionally as needed.
ii. Interview with both registered staff members on the floor approximately 30 minutes after the incident, denied any knowledge of [redacted] complaints of shortness of breath that morning. The RN immediately assessed the resident and administered additional inhalers.
iii. In an interview with the PSW who was involved in the incident, it was confirmed that the response to the resident's complaint's of shortness of breath was "not appropriate". The PSW also confirmed that the registered staff was not notified of the resident's shortness of breath and, as a result, the resident was not assessed or provided with interventions until 30 minutes later, when the Inspector notified registered staff.

resident #47 ed-Dec 8, 201

The resident's concerns of shortness of breath were ignored and therefore the resident was not treated with respect and dignity. [s. 3. (1) 1.]

2. The resident's right to participate fully in the development, implementation, review and revision of his or her plan of care was not fully respected or promoted.

A. During an interview on August 11, 2014, resident #15 indicated that they were not involved in decisions regarding their care, specifically that they recently had testing completed; however, staff had not communicated the results of the testing. A review of the clinical record on August 15, 2014, confirmed the incident as relayed by the resident and the results of the tests from August 6, 2014; however, did not include a record of family or resident notification of the investigative findings. Interview with the charge nurse, by Inspector #528, identified that the home did not typically share this type of information, unless requested outside of care conference time and that these results were not provided to the resident. Discussion with the resident on August 18, 2014, identified that they were still not aware of the findings however their assumption that they were negative as the area was improving. (168) [s. 3. (1) 11. 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:
i. every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity
ii. every resident's right to participate fully in the development, implementation, review and revision of his or her plan of care is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

A) On August 11, 2014, on the first and second floors the doors and the laundry chutes were noted to be accessible, unlocked and unattended prior to noon meal service. Interview with the Administrator confirmed that the areas should be secured for safety. On August 12, 2014, it was observed that the knob on the first floor laundry chute door had been changed to include a lock which was engaged. The Administrator confirmed that a lock had been installed on the door for safety.

B) On August 11, 2014, prior to noon meal service a bottle of Oasis 146 Multi Quat with a label which read "do not drink" was on the steam table in dining room #1. The dining room was unlocked, accessible and without staff in attendance at the time of the observation. Interview with dietary staff confirmed the presence of the bottle, that it was to secured and removed it to the kitchen area. [s. 5.]

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 home is a safe and secure environment for its residents, 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 did not ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

A) The home had a Pharmacy Services Manual with a policy and procedure related to Medication Administration Record (MAR) and Treatment Administration Record (TAR), section 14.0. This procedure directed staff to "use the chart codes located at the bottom of the MAR to assist when a resident does not receive a medication eg. refused, or held" and that "failure to document medication administration properly is considered a medication error".

i. The policy regarding the Medication Administration Record (MAR) and Treatment Administration Record (TAR) was not complied with when staff did not use the chart codes accurately on the MAR, which was then included in the electronic progress notes.
ii. The clinical record for resident #15 identified that specified medications were not administered and then noted that the medications were administered by the Health Care Aide (HCA), based on the chart codes selected by the staff at the time of documentation.
-Documentation of June 15, 2014, and August 16, 2014, identified that the medication Domperidone was not administered and that it was administered by the HCA.
-Documentation of July 2, 2014, and August 8, 2014, identified that the medication Nitro 0.6 mg/hr was not administered and that it was administered by the HCA.
-Documentation of June 8, 2014, and July 1, 2014, identified that the medication ferrous sulphate was not administered and that it was administered by the HCA.
-Documentation of June 30, 2014, identified that the medication atorvasatin was not administered and that it was administered by the HCA.
iii. Interview with the DOC and a registered staff confirmed that PSW/HCA staff administered only topical treatment creams, when delegated and confirmed that they did not administer any oral medications, which was the responsibility of the registered staff.

B) The home's "Cedarwood Village Employee Handbook", dated August 2010, outlined expectations for employee attitude and conduct including but not limited to: "All employees of Cedarwood Village are expected to conduct themselves in a friendly, courteous and professional manner" and that "We expect you to show a positive and helpful attitude, to be honest, trustworthy, reliable, dependable and punctual in all of your workplace activities".

i. In February 2014, an identified employee did not comply with the expectations of the

handbook when they took and consumed narcotic and controlled medications which were ordered and supplied for long term care residents and removed medication control records from the home.
ii. Interviews with the DOC and the identified individual and a review of investigative notes for the incident in February 2014, confirmed the incident and that the employee did not conduct themselves in a professional manner, that their actions at work on the identified shift impaired their ability to complete their required responsibilities and was not acceptable. [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, strategy or system put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the homes, furnishing and equipment were kept clean and sanitary.

A) On August 11, 2014, during an initial tour of the home, the tub lift in the second floor tub room was noted to have large amounts of soap residue on the underside of the lift seat.

B) Throughout the course of the inspection the stairwell at the back of the home was unclean; with cardboard garbage and debris observed on the first floor of the stairwell, and a large amount of what appeared to be insect pods on the stairs leading from the first floor down to the basement.

C) On August 11, 2014 and August 21, 2014 two lounge chairs in the hallway of the second floor, near the elevators, were observed to have stains to the cloth seat backs of both chairs. [s. 15. (2) (a)]

2. The licensee did not ensure that the homes, furnishings and equipment were maintained in a safe condition and good state of repair.

A) On August 11, 2014, the bathtubs located on both first and second floors were observed to have wearing of the plastic along the ledge of the tub, and yellow water stains inside the tubs. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the homes, furnishings and equipment are:
-kept clean and sanitary
-maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. Throughout the course of the inspection, residents #19, #11, #15 were noted to have bed rails in the raised position.

i. The plan of care for resident #19 indicated that the resident required two three quarter bed rails raised when in bed as requested by family.
ii. The plan of care for resident #11 indicated that the resident required two bed rails in the raised position when in bed. (168)
iii. The plan of care for resident #15 indicated that the resident requested to have bed rails in the raised position when in bed. (168)

Review of the plan of care for all three residents did not include a formalized nursing assessment related to use of bed rails. Interview with registered staff confirmed that a formalized bed rail assessment was not completed.

B. In February 2013, the home completed a bed audit, in which all bed systems were assessed for potential zones of entrapment. The bed systems for residents #19 and #11 failed in at least one zone of entrapment. Interview with the DOC confirmed all mattresses have been replaced, however the bed systems have not been re-evaluated to ensure all the bed systems passed all zones of entrapment. [s. 15. (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 the where bed rails were used:
i. the resident is assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident
ii. steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Throughout the course of the inspection, a number of staff and residents commented

that it was not unusual for PSW staff to work without the full staffing complement due to staff calling in sick and an inability to replace the staff despite ongoing efforts, especially during the summer months.

A. It was confirmed by the DOC that the home's current PSW staffing complement was 80 hours on the day shift, 76 hours on the evening shift, and 32 hours on the night shift.

i. Interview with the DOC confirmed that the nursing department, specifically PSW staff worked short for eight hours or more on 45 shifts from July 1, 2014, until August 20, 2014; and on a number of these occasions worked short more than one eight hour shift.
ii. On August 1, 2014, the home was short staffed by a PSW for three eight hours shifts, on the day shift, followed by 14 hours short on the evening shift.

B) On August 15, 2014, day staff on first floor were working one PSW short:

i. At 0925 hours, resident #46 activated their call bell for staff assistance with toileting. Staff did not response to the bell until 0945 hours, at which time the resident had been incontinent.
ii. Staff reported that they were busy with other residents at the time that the bell was activated and were unable to assist the resident until 0945 hours.

C) On August 15, 2014, the home worked one PSW short on the first floor evening evening shift:

i. Dietary staff interviewed on that day reported that the meal service was slow as a result of the staffing complement.
ii. Two residents at table #3 were overheard saying "I hate this wait and it is worse lately", they were served their entree at 17:29 hours.
iii. During the same meal, a PSW was observed to feed three residents at the same time due to working short, as confirmed by staff.

D) On August 17, 2014, the home worked short PSW staff on the day shift:

i. Two residents interviewed verbalized that due to the staffing complement on the identified shift baths were not completed, nor rescheduled.
ii. Staff interviewed confirmed that day baths were not completed as scheduled due to

the time of arrival of additional staff to replace the shift shortages.
iii. A review of Point of Care documentation identified that 10 baths were not recorded as being completed on the identified shift.

E). Staffing shortages was an issue of concern identified during a number of recent Residents' Council Meetings according to the minutes reviewed; most recently staffing was identified in meeting minutes on July 13, 2014.

F) A number of residents interviewed on August 11 and 12, 2014, reported that there were not always enough staff available, when they worked short, to ensure that they received the care and assistance they needed without having to wait a long time.

i. Six residents commented on the wait times to get assistance of staff, when working short;
ii. One resident commented on the delay at meal times, as a result of staffing
iii. One resident reported that they had previously had an episode of incontinence due to staff not able to provide assistance when required. [s. 31. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On August 17, 2014, ten out of ten residents scheduled to receive a bath did not receive one. Review of the Point of Care (POC) documentation did not indicate that all ten residents were bathed on August 17, 2014. These baths were not rescheduled as confirmed by interviews with residents and direct care staff. [s. 33. (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 that each resident of the home is bathed, at a minimum, twice a week by a method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from an absence of greater than 24 hours.

A) In July, 2014, resident #17 was readmitted to the home after from the hospital. Review of the plan of care did not include a skin assessment by a member of the registered nursing staff upon the resident's return to the home. Interview with registered staff confirmed that a skin assessment was not completed by registered staff following the resident's readmission to the home in July 2014. [s. 50. (2) (a) (iii)]

2. The licensee did not ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound

assessment.

A) In October 2013 and March 2014, resident #18 was noted to have new areas of altered skin integrity. Review of the plan of care did not include a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Interview with registered staff confirmed that the new area of altered skin integrity was noted in the nursing progress notes but a skin and wound assessment instrument was not completed.

B) In August 2014, resident #19 was noted to have a new area of altered skin integrity. Review of the plan of care did not include a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Interview with registered staff on August 14, 2014, confirmed that the new area of altered skin integrity was noted in the nursing progress notes but a skin and wound assessment instrument was not completed.

C) Resident #20 was identified to have an ongoing area of altered skin integrity which was assessed and treatment ordered by the physician on July 16, 2014. According to the registered staff interviewed the area was not assessed using a clinically appropriate assessment tool on or around the time that the new treatment was initiated, as the area was present since admission. Initial admission assessment notes reviewed identified the area however did not include specific characteristics of the area such as dimensions, condition of skin etc. which was confirmed with staff interviewed. (168) [s. 50. (2) (b)]

3. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) In October 2013, resident #18 exhibited a new area of altered skin integrity as documented by registered staff. Review of the plan of care did not include any follow up weekly wound assessments until March 2014. Interview with registered staff confirmed that the area of altered skin integrity that was reoccurring from October 2013 to March 2014 had since healed, however weekly wound assessments were not completed and therefore unable to identify at which time the area of altered skin integrity had healed.

B. In September 2013, resident #18 was noted to have an ongoing area of skin breakdown. A weekly wound assessment from September 26, 2013 with pictures taken, confirmed the wound remained open. Review of the plan of care did not include any further weekly wound assessments. A progress note by registered staff in February 2014 indicated that the dressing was present and April 2014 registered staff documented that the wound was healed. Interview with registered staff confirmed that weekly wound assessments were not completed after September 2013 and therefore, was unable to provide an exact date as to when the wound had healed.

C. Resident #20 had an ongoing area of altered skin integrity which was assessed by the physician and a treatment ordered in July 2014. The area was not assessed weekly by the registered nursing staff, according to the clinical record. During the course of the treatment the area was assessed once in July 2014, only which was confirmed during interview with registered staff. (168) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds
i. receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
ii. is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A) The plan of care for resident #19 indicated had a history of responsive behaviours. Interventions for staff included but were not limited: to approaching the resident in a calm, non threatening manner, reminding resident that inappropriate language was unacceptable, to leave resident when exhibiting this behaviour and return, help the resident express feelings to work through anger or fear. Review of the progress notes for incidents of responsive behaviours did not consistently include documentation of interventions and the resident's responses to the interventions.

i. In April 2014, registered staff documented that the resident was "very loud and yelling in the dining room". Interventions or the residents responses to the interventions were not documented.
ii. In May 2014, registered staff noted that the resident was "very rude and demeaning" to personal support worker. Interventions and responses to the interventions were not documented.
iii. In May 2014, registered staff noted that the resident displayed sexually inappropriate behaviours "all shift" . Interventions and responses to the interventions were not documented.
iv. In June 2014, registered staff documented that resident was verbally and sexually abusive towards personal support workers during evening care. The resident was advised that the behaviour was unacceptable as outlined in the plan of care, but the resident's responses tot he interventions were not documented.

Interview with registered staff confirmed that documentation of the resident's responsive behaviours did not always include staff interventions and or the resident's responses to the interventions.

B) The plan of care for resident #14 indicated the resident had responsive behaviours. Interventions for staff included but were not limited to: re-approach the resident after behaviour, administer medications as ordered, redirecting the resident, and provide one on one to decrease angry outbursts. Review of the progress notes for incidents of responsive behaviours did not consistently include documentation of interventions and the resident's responses to the interventions.

i. In June 2014, resident #14 refused to come to the dining room for meal times. Review of the plan of care did not include consistent documentation of interventions or responses to interventions, within relation to refusing meals.

C) The plan of care for resident #16 indicated the resident had responsive behaviours. Interventions for staff included but were not limited to: approaching the resident from the front using a calm tone of voice, removing the resident from other residents for a quiet area to talk, redirecting the resident away from other residents when he is creating disturbances, do not react to it, speak in a calm, firm and reassuring manner at all times, remove anyone that may be in danger from the area, be clear regarding treatment expectations and consequences regarding aggressive behaviour, administer medications as ordered, and never leave resident alone confused co-residents. Review of the progress notes for incidents of responsive behaviours did not consistently include documentation of interventions and the resident's responses to the interventions.

i. In April 2014, resident #16 was in an altercation with a co-resident. There documentation of the incident did not include interventions or the resident's responses to interventions.
ii. In May 2014, it was documented that the resident #16 refused meals; however the documentation did not consistently include the resident's responses to interventions. (156) [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the actions taken to meet the needs of the resident with responsive behaviours includes assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #11: 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 did not ensure that the Residents' Council was responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes and interviews with the Council President and Assistant confirmed that not all concerns or recommendations were responded to in writing, to the Council, within 10 days of receipt.

A review of Meeting Minutes did not include written responses for the following concerns identified:

i. During the October 23, 2013, meeting concerns/recommendations were raised related to requests for a plate warmer, shortage of towels, wait times and a maintenance issue. The minutes for the following meeting held November 22, 2013, did not include a response to the issues identified.
ii. During the November 22, 2013, meeting concerns/recommendations were raised related to request for a plate warmer and wait times. The minutes for the following meeting held December 27, 2013, did not include a response to the issues identified.
iii. During the December 27, 2013, meeting a concern was raised related to staffing. The minutes for the following meeting held January 29, 2014, did not include a response to the issue identified.
iv. During the March 21, 2014, meeting concerns were raised related to soiled laundry and linens on the floor and staff actions. The minutes for the following meeting held April 23, 2014, did not include a response to the issues identified.
v. During the May 28, 2014, meeting a concern was raised related to staff wearing name tags. The minutes for the following meeting held June 25, 2014, did not include a response to the issue identified however noted that the concern was an ongoing problem.
vi. During the June 25, 2014, meeting concerns were raised related to laundry and dietary services. The minutes for the following meeting held July 13, 2014, did not include a response to the issues identified.

It was identified that department heads were to respond to concerns within 10 days, however this information was not shared with the Council until the next scheduled meeting, which was scheduled to be held monthly. (168) [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home. O. Reg. 79/10, s. 72 (1).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized food production system in the home.

The home food production system was not organized to allow adequate quantities of food to be produced and to ensure consistent quality of the food available served to residents.

A) Recipes were not always followed:

i. On August 12, 2014 a staff member was observed adding two teaspoons of thickener to juice for a resident. No recipe was followed.
ii. On August 14, 2014, during the observed meal service, a staff member was observed using a teaspoon to add thickener to juice. A recipe was available outlining that differing quantities of thickener to be used for differing consistencies. The units used were in cubic centimeters (cc), however, a teaspoon was used by the staff which would not ensure accuracy in measuring.
iii. On August 14, 2014, the cook confirmed that a recipe was not followed for the beef barley soup.
iv. On August 14, 2014, two identified residents reported that the food was not cooked consistently and it depended on who the cook was that day.
v. On August 14, 2014, the cook reported that the cream of potato soup served the day before was prepared from frozen and then diced potatoes and spices were added. The recipe stated that it is to be made from scratch or from a package.

B) The food production system did not allow second helpings or in case residents change their minds; on many identified dates, there was 'just enough'.

i. On August 21, the cook reported that she did not even have enough of the chili that day to match the production numbers. It was reported that eight portions were needed for the atrium dining room and there was only enough of the chili to prepare two portions. Twelve portions were required for dining room #1 and there was only had enough to prepare five portions. Seven portions were required for another dining room and there was only enough to prepare three or four portions.
ii. On August 12, 2014 two identified residents spoken to in the dining room reported that the home runs out of food often. On this observed day, the home did not run short of food, however, second helpings were not observed to be offered.
iii. On August 13, 2014, the home did not have any coleslaw or minced meat available for second helpings or if residents changed their minds.
iv. On August 19, 2014, the home did not have any turkey pot pie available for second helpings or if residents changed their minds.
v. On August 20, 2014, the home did not have any muffins available for second helpings or if residents changed their minds. [s. 72. (1)]

2. The licensee did not ensure that all menu items prepared according to the planned menu.

A) Portion sizes were not followed.

i. On August 13, 2014, the therapeutic menu indicated that a #12 scoop was to be used for puree fish, and puree vegetables however, a #10 scoop was used for both of these items instead. A #12 scoop was indicated for puree submarine sandwich meat and puree coleslaw however a #16 scoop was used for these items instead. A #12 scoop was indicated for minced submarine sandwich meat, however, a #10 scoop was used instead. A #8 scoop was indicated for coleslaw, however, a #6 scoop was used instead.
ii. On August 19, 2014, the therapeutic menu indicated that a #12 scoop was to be used for puree bread, however, a #24 scoop was used instead. The menus indicated that a #8 scoop was to be used for puree turkey pot pie, however, a #12 scoop was used instead.
iii. On August 20, 2014, the therapeutic menu indicated that a #12 scoop was to be used for minced chicken, however, a #30 scoop was used; a #12 scoop was indicated for puree chicken, however a #10 scoop was used. A #8 scoop was indicated for macaroni salad, however a #12 scoop was used instead; a #12 scoop was indicated for minced macaroni salad, however, a #10 scoop was used in one dining room and a #8 scoop was used in another. A #12 scoop was indicated for puree macaroni salad, however, a #8 scoop was used instead. A#8 scoop was indicated for cottage cheese, however a #10 scoop was used instead. A #8 scoop was indicated for puree cottage cheese, however, a #12 scoop was used; a #12 scoop was indicated for puree muffin, however, a #16 scoop was used. The therapeutic menu indicated that a 4 oz piece of watermelon and 1 pc pear half, 4 oz cantaloupe and 8 pc grapes were to be provided for those on a regular textured diet with the cottage cheese fruit plate. The observed dining room was provided with a #30 scoop of mixed tropical fruit instead. A #12 scoop was indicated on the menu for puree bread, however a #24 scoop was used instead.

B) Menu items were not prepared according to the planned menu
i. The therapeutic menu indicated that plums were to be prepared for dessert on August 19, 2104, however, peaches were prepared instead.
ii. On August 20, 2014, the therapeutic menu indicated that a 4 oz piece of watermelon and 1 pc pear half, 4 oz cantaloupe and 8 pieces of grapes were to be provided for those on a regular textured diet with the cottage cheese fruit plate. These items were not prepared and the home served mixed tropical fruit instead.
iii. The therapeutic menu indicated that pineapple tidbits were to be prepared for dessert on August 20, 2014, however, oranges were prepared instead [s. 72. (2) (d)]

3. The licensee did not ensure that menu substitutions were documented on the production sheets.

The therapeutic menu indicated that plums were to be prepared for lunch on August 19, 2104, however, peaches were prepared instead. The therapeutic menu indicated that pineapple tidbits were to be prepared for lunch on August 20, 2104, however, oranges were prepared instead. The menu substitutions were not documented on the production sheets as confirmed with the cook on August 21, 201. [s. 72. (2) (g)]

4. The licensee did not ensure that there was a cleaning schedule for:
* the food production areas
* servery areas, and
* dishwashing areas and that staff comply with this schedule

A) The servery areas, in particular the steam tables in dining rooms #2 and #4 were observed to be in need of cleaning. In the main kitchen, the floors, walls, garbage cans, stand alone freezer,dessert/vegetable fridge and the walk in fridge in the basement were in need of deep cleaning.

The FSM confirmed on August 14, 2014 that the kitchen areas were in need of cleaning. Interview with dietary staff and the FSM on August 14, 2014, the home did not have cleaning schedules for the food production areas, servery areas and dishwashing areas. The FSM was in the process of changing the schedules and therefore the schedules were not available to staff. [s. 72. (7) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that there is an organized food production system in the home
ii. all menu items are prepared according to the planned menu, and iii. that there was a cleaning schedule for the food production areas servery areas, and dishwashing areas and that staff comply with this schedule, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there is a process to report and locate resident's lost clothing and personal items.

A) During stage one resident interview on August 11 and 12, 2014, residents #12, #15, and #19 reported that personal clothing items have gone missing, taking up to six months for them to return. Interview with registered staff and PSWs identified a variety of different strategies used to find resident's missing clothing. Interview with the DOC confirmed that the home does not have a standardized process for staff to follow when resident or families report lost clothing and personal items. [s. 89. (1) (a) (iv)]

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 their is a process to report and locate the resident's lost clothing and personal items, to be implemented voluntarily.

WN #14: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A) Throughout the course of the inspection, a room shared amongst three residents was noted to have a sign posted outside the room indicating that anyone entering the room were to wear gloves and long sleeves.

i. Interview was conducted with three different personal support workers who were unable to identify the resident affected or the organism requiring isolation. It was confirmed with registered staff that in July 2014, resident #48 was identified as testing positive to an antibiotic resistive organism and required contact precautions.
ii. Review of the document the home refers to as the care plan, did not include any directions to staff related to the type or location of organism, or isolation precautions required (other than a contact isolation sign outside of the room).
iii. Interview with the DOC confirmed that the plan of care did not provide clear directions to staff and others who provide direct care to resident within relation to contact precautions for resident #48. [s. 6. (1) (c)]

2. The licensee has did not ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A) The most recent quarterly Minimum Data Set (MDS) assessment dated August 7, 2014 for resident #10 indicated that the resident was incontinent of bowels and frequently incontinent of bladder.

i. Review of Point of Care (POC) documentation identified that the resident was frequently incontinent of bowels and incontinent of bladder.
ii. Interview with the RAI coordinator confirmed that based on POC documentation, the resident should have been coded as frequently incontinent of bowels and incontinent of bladder and the assessments were therefore, not consistent.
iii. Staff and others involved in the care of the resident did not collaborate with each other in the assessment of the resident so that PSW's documentation on POC was not consistent with the MDS assessment for August 2014.

B) The most recent quarterly MDS assessment dated July 16, 2014, for resident #14 indicated that the resident was incontinent of bladder.
i. Interview with direct care staff reported on that the resident was occasionally incontinent of bladder and the plan of care for the resident indicated that the resident was frequently incontinent.
ii. Interview the RAI coordinator reported that based on the POC documentation, the resident was coded correctly, however, the plan of care was not consistent with the resident's assessment of incontinence. [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan was provided to the resident as specified in the plan.

A) After lunch service on August 20, 2014, resident #41 was observed to propel themselves in their wheelchair from the dining room at one end of the hallway, to [redacted] their bedroom at the other end of the hallway; the entire length of the unit.

ed-Dec 8, 2014

i. Review of the plan of care for the resident indicated that the resident was able to propel themselves short distances, staff were to encourage the resident to use two. [redacted] arms to propel themself but required the assistance of staff to push the wheelchair for longer distances. ii. Interview with the resident while attempting to propel [redacted] down the hallway, and they confirmed that they were tired and needed help. themself

ed-Dec 8 20

ed-Dec 8 2014.

iii. Interview with direct care staff confirmed that the staff usually offered assistance to the resident as outlined in the plan of care. [s. 6. (7)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensed did not ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A) The home's policy "ADM-II-245 Abuse and Neglect Policy" last revised March 18, 2014 identified that Maplewood Nursing Homes Ltd senior staff are to immediately report any incidences of alleged or actual resident abuse to the Director, in accordance with section 23 of the Long-Terms Care Homes Act, 2007.

i. In the spring and early summer of 2014, resident #17 was involved in altercations with resident #42, resulting in superficial injury to resident #17 on both dates. Review of the
plans of care for both residents did not include a report submitted to the Director outlining the incident of resident to resident abuse.
ii. Interview with the Director of Care (DOC) confirmed that the home did not complete a critical incident report to the MOHLTC for each incident of resident to resident abuse. [s. 20. (1)]

[redacted]

LW Dec 8, 2014

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

[redacted]

[redacted] :

[redacted]

[redacted]

CO-Dec 8, 2014

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident who cannot brush their own teeth received physical assistance or cueing.

A) The plan of care for resident #17 identified that the resident was able to brush their own teeth but due to poor vision required assistance of staff to set up the resident by applying toothpaste to brush in the morning and evening.
i. On [redacted] at 13:00 hours, the resident's toothbrush was dry and the toothpaste appeared to be unused. August 14, 2014 to Dec 8, 2014
ii. Interview with the resident confirmed that he did not receive set up for oral care by staff that morning. Interview with the personal support worker confirmed that she did not assist the resident with applying toothpaste to the toothbrush during morning care on [redacted], and was unsure if the resident brushed their teeth themself. [s. 34. (1) (b)] August 14, 2014 to Dec 8, 2014

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that when the resident has fallen, the resident was assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) In July 2014, resident #17 had an two unwitnessed fall, which resulted in a transfer to hospital.
i. Review of the progress notes included a description of the event and assessment of the resident including vital signs and documentation of injuries. The clinical health record for resident #17 did not include a post-falls assessment using a clinically appropriate assessment instrument after the fall.
ii. Interview with registered staff confirmed that after a fall the home's policy "NDM-III-400: Falls Prevention and Management Program", last revised July 2011 directed staff to complete a Falls Risk Assessment if the resident has two falls within 72 hours.
iii. Interview with registered staff confirmed that a Falls Risk Assessment, after the two falls in July 2014, was not included as part of the clinical health record. [s. 49. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A) The plan of care for resident #46 indicated that the resident was incontinent of bladder, usually continent of bowel and was totally dependent on staff; requiring two staff for assistance, and the use of a hoyer lift.

i. On August 15, 2014 at 9:25 hours, resident #46 activated the communication response system. The Inspector did not observe staff enter the resident's room until 9:45 hours, approximately 20 minutes later.
ii. Interview with the resident the same day confirmed that when they initially activated the communication response system they needed to have a bowel movement. The resident also stated that by the time the staff came to assist, it was too late and they "had an accident".
iii. Interview with PSWs and review of documentation confirmed that the resident was incontinent of stool.

The resident was not provided toileting assistance by staff to manage and maintain continence. [s. 51. (2) (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the menu cycle was reviewed by the Residents' Council.

A review of recent Residents' Council Meeting Minutes by inspector 168, and Food Committee Meeting Minutes by Inspector #156, did not include a review of the menu cycle by the Council or Committee. Interview with the FSM by Inspector #156 confirmed that the Committee did not review the menu cycle. [s. 71. (1) (f)]

WN #21: 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 did not ensure that the advice of the Residents' Council was sought out in the development and carrying out the satisfaction survey.

A review of the Residents' Council Meeting Minutes and interviews with the Council President and Assistant identified that the licensee did not seek the advice of the Council in the development and carrying out the satisfaction survey. [s. 85. (3)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (3) Even if the licensee does not have an agreement with the resident, the resident is responsible for the payment of amounts charged by the licensee for basic accommodation in accordance with paragraph 1 or 2 of subsection (1). 2007, c. 8, s. 91. (3).

Findings/Faits saillants :

1. The licensee did not ensure that for anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.

In June 2014 resident #42 was charged $13.00 for "dry cleaning" and in July 2014 another $13.00 for "incontinent products", as stated on the resident's Statement of Account.

i. Interview with the DOC confirmed that both "incontinent products" and "dry cleaning" charges to the resident was for the dry cleaning of chair cushions from the atrium in the Retirement Residence.
ii. Review of the admission agreement for Schedule B-Unfunded Services, signed by the residents SDM in July 2009, did not include the authorization for dry cleaning charges of furniture.
iii. Interview with the SDM of resident #42 who confirmed they were billed and paid $13.00 for dry cleaning charges of a seat cushion of a lounge chair in the atrium on two separate occasions. [s. 91. (3)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with conditions to which the licensee was subject.

Section 4.0 under Schedule B of the Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN), under the Local Health System Integration Act 2006, reads "The Health Service Provider shall use the funds allocated for an Envelope for the use set out in the Applicable Policy".
i. The Long-Term Care Home funding Policy of July 1, 2013, for Eligible Expenditures for Long-Term Care Homes, Nursing and Personal Care (NPC) Envelope Section 1. b) reads "direct nursing and personal care includes the following activities: assistance with the activities of daily living, including personal hygiene services, administration of medications and nursing care".
ii. PSW staff were observed to complete non nursing activities on August 13, and 15, 2014. Staff were observed folding home laundry specifically washcloths and bath towels. Work Routines reviewed and PSW staff interviewed confirmed that this task was included in their usual routine and an expectation for the specified shifts.
iii. Interview with the Administrator confirmed that the PSW staff were responsible for this non-nursing activity and were paid from the NPC envelope while completing this task. [s. 101. (4)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee did not once in every calendar year, conduct an evaluation to determine the effectiveness of the policy, and identify what changes and improvements were required to minimize restraining.

Interview with the DOC identified that she was not able to provide an evaluation of the Use of Restraints Policy and confirmed that the home did not conduct and annual evaluation of the policy in 2013/14. [s. 113. (b)]

WN #25: 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 did not ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

Resident #20 had an area of altered skin integrity. The area was assessed and the physician ordered two topical treatments to be applied one once a day and the second three times a day for 14 days.

i. A review of the July 2014, Treatment Administration Record (TAR) identified that the medications were only signed as administered on 6 of 14 occasions and 10 of 42 occasions. ii. Interview with the registered staff confirmed that if the TAR was not signed it was likely that the treatment was not completed. Interview with a PSW indicated that if a treatment was not signed for on the TAR it would not have been administered. [s. 131. (2)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written record kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Interview with the DOC identified that she was not able to provide a written annual evaluation of the Infection Prevention and Control Program for 2013 or 2014. [s. 229. (2) (e)]

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

Issued on this 6th day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
C DiTomasso # 528

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), CAROL POLCZ (156), LISA VINK (168)
Inspection No. / No de l'inspection :	2014_267528_0027
Log No. / Registre no:	H-001076-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2014
Licensee / Titulaire de permis :	MAPLEWOOD NURSING HOME LIMITED 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
LTC Home / Foyer de SLD :	CEDARWOOD VILLAGE 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WALTER SGUAZZIN

To MAPLEWOOD NURSING HOME LIMITED, 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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the dining and snack service includes food and fluids served at a temperature that is both safe and palatable to the residents.

The plan is to be submitted on or before September 30, 2014, to Carol Poltz by email: Carol.Poltz@ontario.ca.

The plan is to be implemented by October 31, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

Food temperatures were not found to be in a safe and palatable range. The temperature range in which food-borne bacteria can grow, known as the danger zone is 4 to 60 degrees Celsius (°C) (40 to 140 degrees Farenheit(°F)). A poster found in the home on the third floor dining area on May 23, 2014 indicated the holding temperatures for cold items must be at 4°C and hot food items must be 74°C prior to service.

A) Food temperatures at all meal times have been an ongoing concern in the home.

i. On August 11 and 12, 2014, seven residents expressed concerns regarding food temperatures.
ii. On August 15, 2014, one resident stated the the fish was "stone cold"
iii. According to the minutes of the Resident Council Food Committee, the residents had reported the food temperatures being too cold at seven out of nine meetings since August 2013.

B) Food temperatures were taken at meal times on four different days:

i. thirteen cold food items were probed for temperatures which read over four degrees celcius
ii. seven hot food items were probed for temperatures which read over 60 degrees celcius (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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.

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

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 8th day of September, 2014

Signature of Inspector / Signature de l'inspecteur : CDiTomasso #528

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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