Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
December 9, 10, 14, and 15, 2010	2010_192_2660_09Dec092034	Critical Incident H-02921

Licensee/Titulaire
Delhi Nursing Home Limited, 750 Gibraltar Street, Delhi, Ontario, N4B 3B3

Long-Term Care Home/Foyer de soins de longue durée
Delhi Long Term Care Home, 750 Gibraltar Street, Delhi, Ontario, N4B 3B3

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector #192, Marilyn Tone Nursing Inspector #167

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspectors spoke with: Administrator/Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Nurses Aides, Personal Support Workers, Physiotherapist, and the Physiotherapist Assistant.

During the course of the inspection, the inspectors: Reviewed health records, reviewed policies and procedures related to restraints and falls management/prevention, reviewed statements and incident reports.

The following Inspection Protocols were used during this inspection: Minimizing of Restraining, Hospitalization and Death, Falls Prevention, Sufficient Staffing, Training and Orientation, and the Critical Incident Response Inspection Protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

15 WN
4 VPC
6 CO: CO # 001, # 002, # 003, # 004, # 005, #006.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with Long Term Care Homes Act, 2007, S.O. 2007,c. 8, s. 6(1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

A specified resident's plan of care stated that there was to be a seat belt in place when in the wheelchair, and that the seat belt when worn, was to be checked hourly for safety. The plan of care directs staff to remove the seat belt, reposition the resident and reapply the seatbelt every two hours.
During interviews with Personal Support Workers (PSWs), conflicting information was provided related to the interventions in place to manage fall and restraint risks for the resident.

There was no clear direction in the resident's plan of care on how to correctly apply the restraint despite staff members confirming that the resident had specific needs related to restraint use. Other interventions identified by staff as being effective were never added to the plan of care.

Inspector ID #:	Nursing Inspectors # 192 and # 167

WN #2: The Licensee has failed to comply with Long Term Care Homes Act 2007, O. Reg. 79/10, s. 28 (b)

Where, immediately before the coming into force of this section, there is a plan of care in place with respect to a resident, the licensee of the long term-care home shall ensure,

(b) that the plan of care is reviewed during that six months if the resident's needs change, the care in the plan of care is no longer necessary or the care in the plan of care has not been effective.

Findings:

The specified resident sustained several falls early in 2010. Due to the frequency of falls from the wheelchair, a restraint was applied to the wheelchair and the plan of care was updated. The resident began to experience an increase in falls. No falls reassessment was completed.

Restraint assessments/reassessments were not completed and alternatives were not tried to ensure the safety of the specified resident.

The plan of care for the specified resident was not reviewed and revised despite the interventions being ineffective in maintaining the resident's safety.

Inspector ID #:	Nursing Inspectors #192 and #167

WN #3: The Licensee has failed to comply with Long Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 6(4)(a)

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;

Findings:

Restraint assessments were completed by nursing staff as part of the Resident Assessment Protocols (RAPS). There is no indication of interdisciplinary involvement from the time that the restraint was applied until the incident occurred.

1) A physiotherapy/occupational therapy referral was initiated for the specified resident as a result of a fall from the wheelchair. A response was documented by the physiotherapy assistant without consultation with the physiotherapist.
2) During interviews with physiotherapy and nursing staff, care providers were able to suggest interventions that they found to be effective in minimizing the risk of falls and harm for the specified resident, from the restraint. There was no collaboration related to the consistent implementation of these potential interventions.

Inspector ID #:	Nursing Inspector #192 and #167

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 ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with Long Term Care Homes Act, 2007, S.O. 2007,c. 8 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.

Findings:

The care set out in the specified resident's plan of care was not provided on the day and evening shifts.

1. The plan of care indicates that for toileting the resident requires the assistance of two staff and the correct lift: During an interview, one PSW indicated that she had transferred the resident without the assistance of other staff or the use of the lift.
2. Documentation under mobility on the resident's plan of care indicates that footrests should remain off the wheelchair. Statements from staff indicated that footrests were in use at the time of the critical incident.
3. Toileting plan indicates that the resident should be toileted ac(before), pc (after) meals, qhs (at bed

time) and prn (as necessary). Staff working the day and evening shifts indicated that the resident was not toileted for more than 6 hours.

4. The resident's plan of care related to restraints indicates that the resident should be checked every hour for safety and repositioned every two hours. The resident was not checked and repositioned according to the interventions set out in the plan of care.

Inspector ID #:	Nursing Inspector #192 and #167

WN #5: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8, s. 29 (1)(a), (b)

Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with.

Findings:

1. The home's policy titled "Restraints", dated as revised September 2010 and in effect does not reflect current legislation on the management of restraints.
   i) Prohibited restraints are included in the policy – "physical restraints – i.e. Jacket/vest restraints," and are allowed to be used while a resident is in bed.
   ii) There is no indication in the policy of the need to reassess a restraint, or the frequency of reassessment.
2. The home's policy on restraints was not complied with.
   i) A specified resident was not monitored hourly or repositioned every two hours while restrained.

Inspector ID #:	Nursing Inspector #192 and #167

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with Long Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 35 (a)

Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,

(a) to restrain the resident

Findings:

During interview with the Administrator, it was identified that a specified resident wears a prohibited restraint when in bed.

1. On review of the resident's health record, it is identified that there is a signed consent for a prohibited restraint to be used while in bed. There is a signed physician's order for a prohibited restraint for use in bed.
2. During interview with a Registered Nurse, it was confirmed that a specified resident wears a prohibited restraint when in bed.
3. A restraint was observed in the top drawer of the specified resident's bedside table.
4. The resident's plan of care gives staff direction for the use of a restraint while in bed.

5. Paragraph 2 of section 112 of the Long-Term Care Homes Act 2007 prohibits the use of specified restraints.

NOTE: Orders # 001 and #002 were served on December 15, 2010, to be complied with immediately.

Inspector ID #:	Nursing Inspector #192 and #167

WN #7: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 112 (2)

For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

2. Vest or jacket restraints.

Findings:

During interview with the Administrator, it was identified that a specified resident wears a jacket restraint when in bed.

1. On review of the resident's health record, it is identified that there is a signed consent for a jacket restraint. There is a signed physician's order for a jacket restraint.
2. During interview with a Registered Nurse, it was confirmed that a specified resident wears a jacket Restraint.
3. A jacket restraint was observed in the top drawer of the specified resident's bedside table.
4. The resident's plan of care gives staff direction for the use of a jacket restraint.

Inspector ID #:	Nursing Inspector #192 and #167

Additional Required Actions:

CO # - 002 was served on the licensee December 15, 2010. Refer to the "Order(s) of the Inspector" form. To be complied with immediately.

WN #8: The Licensee has failed to comply with Long Term Care Homes Act, 2007, O. Reg. 79/10, s. 71 (3) (b), (c).

The licensee shall ensure that each resident is offered a minimum of,

(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

(c) a snack in the afternoon and evening.

Findings:

1. No evening nourishments or beverages were served on December 5, 2010 as confirmed by interviews with nursing staff.

Inspector ID #:	Nursing Inspector #192 and #167

WN #9: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 107(1) 2, (2)

(1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

(2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact.

Findings:

1. A unexpected death was not reported immediately to the Director.
2. The licensee did not make a report immediately related to a sudden death using the Ministry's method for after hours emergency contact.

Inspector ID #:	Nursing Inspector #192 and #167

WN #10: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 110(2) 3, and 4.

Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)

Findings:

A specified resident's restraint was not checked as required.

1. The specified resident was not monitored hourly or more frequently. All staff interviewed confirmed that the resident did not receive routine hourly checks.
2. The specified resident did not have the restraint removed and have assistance to reposition every two hours.

Inspector ID #:	Nursing Inspector #192 and #167

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #11: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 110(6)

(6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary.

Findings:

During interview with the Administrator, it was identified that a specified resident wears a prohibited restraint

when in bed.

1. On review of the resident's health record, it is identified that there is a signed consent for a prohibited restraint to be used while in bed. There is a signed physician's order for a restraint in bed.
2. During interview with a Registered Nurse, it was confirmed that a specified resident wears a restraint when in bed.
3. A restraint was observed in the top drawer of the specified resident's bedside table.
4. The resident's plan of care gives staff direction for the use of a restraint while in bed.

Inspector ID #:	Nursing Inspector #192 and #167

Additional Required Actions:

CO # - 001 was served on the licensee on December 15, 2010. Refer to the "Order(s) of the Inspector" form.

WN #12: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 113(a)

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;

Findings:

1. There is a Falls/Restraint Committee in place at the home but upon review of the minutes for meetings held, it was noted no analysis of the restraints used within the home has been completed. The effectiveness of the restraints or risks associated with restraint use for each resident was not conducted.

Inspector ID #:	Nursing Inspector #192 and #167

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 by ensuring that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 49 (1) (2)

(1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches, and the use of equipment, supplies, devices and assistive aids.

(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.

Findings:

1. The home has a draft policy on "Fall Risk Assessment", dated as revised October 2010 (draft) and "Falls Management" dated as revised October 2010 (draft) to reflect current legislation. These policies have not been implemented within the home.

2. Post fall assessments were not routinely completed for a specified resident despite the increasing number of falls and associated risk of restraint use the resident experienced.

Inspector ID #:	Nursing Inspector #192 and #167

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 to ensure that the falls prevention and management program is in compliance with and is implemented in accordance with all applicable requirements under the Act; to be implemented voluntarily.

WN #14: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 66(1)

(1) Every licensee of a long-term care home shall ensure that there is a designated lead for the recreational and social activities program.

Findings:

1. During interview with the Administrator/Director of Care it was identified that the Life Enrichment Coordinator resigned September 18, 2010.
2. As of December 15, 2010 the home still does not have a designated lead for the recreational and social activities program.

Inspector ID #:	Nursing Inspector #192 and #167

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 by ensuring that there is a designated lead for the recreational and social activities program to be implemented voluntarily.

WN #15: The Licensee has failed to comply with Long Term Care Homes Act, 2007 - O. Reg. 79/10, s. 75(1)

(1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home.

Findings:

1. During interview with the Administrator/Director of Care it was identified that the home has not had a Food Services Supervisor since May 28, 2010.
2. As of December 15, 2010 the home still has no nutrition manager working in the home.
3. The Registered Dietician is currently on site at the home one day per week.

Inspector ID #:	Nursing Inspector #192 and #167

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Debra Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 6, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Debora Saville	**Inspector ID #**	192
Log #:	H - 02921		
Inspection Report #:	2010_192_2660_09Dec092034		
Type of Inspection:	Critical Incident		
Date of Inspection:	December 9, 10, 14 and 15, 2010		
Licensee:	Delhi Nursing Home Limited, 750 Gibraltar Street, Delhi, Ontario, N4B 3B3		
LTC Home:	Delhi Long Term Care Home, 750 Gibraltar Street, Delhi, Ontario, N4B 3B3		
Name of Administrator:	Hanna Lammel-Joseph		

To Delhi Nursing Home Limited, you are hereby required to comply with the following orders by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)]

Pursuant to: O. Reg. 79/10 s. 110 (6)

Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary.

Order:

The licensee shall immediately refrain from using a prohibited restraint, or any other restraint, while any resident is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary.

Grounds:

During interview with the Administrator on December 15, 2010 it was identified that a resident wears a prohibited restraint when in bed.

1. On review of an identified resident's medical record it is identified that there is a signed consent for a restraint to be used while in bed, and a signed physician order for a restraint in bed.

2. During interview with an RN on December 15, 2010 it was confirmed that a specific resident wears a restraint when in bed.

3. On December 15, 2010, a prohibited restraint was observed in the top drawer of a resident's bedside table.

4. The resident's narrative plan of care gives staff direction for the use of a restraint while in bed.

This order must be complied with by:	Immediately

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)]

Pursuant to: O. Reg. 79/10 s.112(2)

For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

2. Vest or jacket restraints.

Order:

The licensee shall immediately refrain from using a prohibited restraint for any resident. The licensee shall ensure the safety of an identified resident and all other residents, despite the removal of the restraint.

Grounds:

During interview with the Administrator on December 15, 2010 it was identified that a resident wears a prohibited restraint when in bed.

1. On review of an identified resident's medical record it is identified that there is a signed consent for a prohibited restraint to be used while in bed, and a signed physician order for a prohibited restraint in bed.

2. During interview with an RN on December 15, 2010 it was confirmed that a specific resident wears a restraint when in bed.

3. On December 15, 2010, a prohibited restraint was observed in the top drawer of a resident's bedside

table.

4. The resident's narrative plan of care gives staff direction for the use of a restraint while in bed.

This order must be complied with by:	Immediately

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: Long Term Care Homes Act, 2007 S.O. 2007, c. 8, s. 29(1) (a)

Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations;

Order:

The licensee shall revise the policy to minimize the restraining of residents called, "Restraints", to comply with the LTCHA and its regulations including but not limited to, the identification of restraints prohibited for use and to provide clear direction on the reassessment of restraints.

Grounds:

The home's policy and procedure related to restraints has not been updated to reflect current legislation.

1. The home's policy titled "Restraints", dated as revised September 2010 and in effect on December 5, 2010 does not reflect current legislation on the management of restraints.
   i) Prohibited restraints are included in the policy – "physical restraints – i.e. Jacket/vest restraints," are allowed to be used while a resident is in bed.
   ii) There is no indication in the policy of the need to reassess a restraint, or the frequency of reassessment.

This order must be complied with by:	January 14, 2011

Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: Long Term Care Homes Act, 2007 S.O. 2007, c. 8, s. 29(1) (a)(b)

Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations;

(b) shall ensure that the policy is complied with.

Order:

The licensee shall ensure that all staff are trained on the revised "Restraint" policy referred to in order 003 and that this policy is complied with.

Grounds:

The home's policy and procedure related to restraints has not been updated to reflect current legislation.

1. The home's policy titled "Restraints", dated as revised September 2010 and in effect on December 5, 2010 does not reflect current legislation on the management of restraints.
   i) Prohibited restraints are included in the policy – "physical restraints – i.e. Jacket/vest restraints," and are allowed to be used while a resident is in bed.
   ii) There is no indication in the policy of the need to reassess a restraint, or the frequency of reassessment.
2. The home's policy on restraints was not complied with.
   i) A specified resident was not monitored hourly or repositioned every two hours while restrained.

This order must be complied with by:	January 21, 2011

Order #:	005	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: O. Reg. 79/10, s. 110 (2) 3,4

Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)

Order:

The licensee shall prepare and submit a plan by January 11, 2011 for achieving compliance to meet the requirement that where a resident is restrained by a physical device under section 31 of the Act, that the resident is monitored and repositioned in accordance with O. Reg. 79/10 section 110(2)3,4. This plan shall be implemented. The plan is to be submitted electronically to Nursing Inspector Debora Saville, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, at debora.saville@ontario.ca.

Grounds:

1. A specified resident's restraint was not checked for more than six hours. Hourly checks are required.

2. All staff interviewed confirm that a specified resident did not receive routine hourly checks. 3. A specified resident did not have the restraint removed and have assistance to reposition every two hours.	
This order must be complied with by:	Immediately

Order #:	006	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: O. Reg. 79/10, s. 75 (1)

(1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home.

Order:
The licensee shall prepare and submit a plan by January 14, 2011 for the recruitment of a nutrition manager for the home and shall include in the plan interim measures to provide for the supervision of the dietary services and nutritional care of the residents of the home. This plan shall be implemented. The plan is to be submitted electronically to Nursing Inspector Debora Saville, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, at debora.saville@ontario.ca.

Grounds:

1. During an interview with the Administrator/Director of Care, it was identified that the home has not had a nutrition manager since May 28, 2010. Applications have been received and some interviews were conducted in June and July of 2010.
2. As of December 15, 2010 the home still does not have a nutrition manager working in the home.
3. The Registered Dietician is currently only on site at the home one day per week.

This order must be complied with by:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 6th day of January 2011.	
Signature of Inspector:	Debora Saville
Name of Inspector:	Debora Saville
Service Area Office:	Hamiltion Service Area Office 119 King St. West, 11th Floor Hamilton ON L8P 4Y7