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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 5, 13, Apr 7, 2014	2014_207147_0006	H-000256-14	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

LALEH NEWELL (147), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4, 5, 6, 7, 10, 11, 13, 14, 2014

Complaint inspection H-000290-14 was completed concurrently with this inspection
The following orders were reviewed during this inspection:
H-000276-14 follow up to H-000632-13 CO #003 - s. 20(2)
H-000275-14 follow up to H-000632-13 CO #002 - s. 19(1)
H-000274-14 follow up to H-000632-13 CO #001 - s. 3(1)
H-000644-13 follow up to CO #001 - s. 6(2)

During the course of the inspection, the inspector(s) spoke with residents, family members, Registered Nursing staff, front line nursing and dietary staff, maintenance personnel, the Nutrition Manager, Director of Resident Care, Assistant Director of Resident Care, and Administrator.

During the course of the inspection, the inspector(s) toured the home, observed care, reviewed relevant clinical health records, relevant policies and procedures, laundry, maintenance and housekeeping practices, and food production systems.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure the staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. [s. 23.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, not all bed systems were evaluated in accordance with evidence-based practices to minimize risk to residents.
A) The home commissioned an external contractor to complete a bed entrapment zone audit of all the resident bed systems on June 3, 2013. The results of the audit concluded that over 47% of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. Since that time, the management of the home had not instituted measures to minimize or mitigate potential risk to many of those residents.
B) During a tour of the home, some gaps between head boards and mattresses, between the upper and lower rails, and bed rails and mattresses were observed. These were areas that failed bed safety parameters during the audit or beds that were changed after the audit without a re-assessment of the safety zones. The home had a mix of bed models and mattresses of different ages. Some beds were furnished with quarter length assist bed rails and others with older full length rails. Bed mattresses were noted to be too short for the bed frames. Mattresses that were too short created excessive gaps at the head or foot of the bed (entrapment zone 7). A number of bed frames had missing mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the

frame of the bed.
C) At the time of this inspection, many of the failed beds continued to be used by residents who used bed rails. Since the audit, some new mattresses and bed frames had been purchased, however the management did not identify or document which beds they replaced or were applied to. The beds that received a new mattress also did not receive a post entrapment zone assessment to determine if the new mattresses were adequate for the specific bed frame. [s. 15. (1) (a)]

2. [O.Reg. 79/10, s. 15(1)(b)]
The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Bed F125-A failed the Joerns entrapment risk assessment for zones one and three on June 3, 2013. The bed on March 13, 2014 was not observed to have mattress keepers in place and the mattress had slid to the side of the bed frame, creating a gap approximately five to six inches between the right side rails and the mattress. A large gap approximately five and a half inches was also noted between the top and bottom bedrail.
The plan of care identified a bumper pad was required on the left bedrail, however, staff confirmed the bumper pad was not being consistently used as the resident would remove it.

B) Bed F204-1 had a large gap at the end of the bed, approximately five inches and another gap approximately three inches between the mattress and the quarter rails at the head of the bed on the right side. The bed had molded mattress keepers, however the mattress was too short for the bed frame and did not fit within the mattress keepers. The bed had passed the Joerns entrapment risk assessment of June 3, 2013, however the Director of Resident Care confirmed the bed had been replaced since the Joerns assessment and had not been assessed for safety since the replacement.

C) Bed F207-B failed the Joerns entrapment risk assessment for zones one and three on June 3, 2013. The bed on March 13, 2014 was observed to have a large gap, approximately three to four inches between the mattress and the left siderail.
Interview with registered staff confirmed that the staff do not complete an assessment for bedrails unless they are considered a restraint. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 902 was served on the licensee. CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
   i. a physician,
   ii. a registered nurse,
   iii. a registered practical nurse,
   iv. a member of the College of Occupational Therapists of Ontario,
   v. a member of the College of Physiotherapists of Ontario, or
   vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 33(4)]
Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD, the use of the PASD was reasonable given the resident's condition, consent was obtained, and the device was approved.
A) During interview resident #204 confirmed that the use of two quarter rails while they were in bed was for the purpose of a PASD to assist the resident with bed mobility and safety. The health records did not include an assessment identifying that alternatives were tried prior to the use of the bed rails. Interview with the registered staff and the Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.
B) Resident #216 used one quarter and one half rail when in bed as a PASD to assist with bed mobility. The health records did not include an assessment identifying that alternatives were tried prior to the use of the bed rails. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.
C) Resident #232 used one full bedrail while they were in bed as a PASD to assist with bed mobility. The health records did not include an assessment identifying alternatives were tried prior to the use of the bed rails. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.
D) Resident #192 used a seatbelt while in their wheelchair as a PASD for safety. Interview with the registered staff and Personal Support Worker (PSW) confirmed that the resident was able to undo the seatbelt and it was used for safety and comfort while the resident was in their wheelchair. The health records did not include an assessment identifying alternatives were tried prior to the use of the seatbelt. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD. [s. 33. (4)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 90(2)(a)]
Procedures were not developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.

A) On March 5, 2014 two mechanical lifts on the 2nd floor were not kept in good repair and maintained at a level that met manufacturer specifications. Review of the home's operating and product care instruction for the Medi-Lifter 4 – Total lift, indicated that the home's personnel in charge of the maintenance and safety inspection of the patient handling devices were to conduct and complete a monthly inspection details form and if any devices were noticed to be defective, they must replace it with an original component.
The two mechanical lifts were observed to have duct tape around the pivot of both lifts. Interview with the home's Maintenance Manager confirmed that the home had not been consistently conducting regular maintenance checks on all the mechanical lifts in the home as the home was no longer utilizing an external company for these audits and had been conducting the maintenance checks of the mechanical lifts internally. Review of the home maintenance logs also confirmed that these maintenance checks were not being conducted on a consistent basis to ensure all components of the lifts were in good repair and maintained at a level that met the manufacturer specification.
B) It was also noted on March 5, 2014 that the slings used for most of the mechanical lifts on both floors were frayed, torn or damaged.
Review of the home's operating and product care instruction for the Medi-Lifter 4 – Total lift, indicated that the staff were never to use damaged, torn or frayed slings. Interview with the Maintenance Manager and ADRC confirmed that the home had been aware of these frayed and torn slings and new slings had been ordered, however the slings were not taken out of service and staff continued to use the frayed slings for resident transfers while awaiting delivery of new slings. r 90. (2) (a) [s. 90. (2) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 221(1)6]
The licensee failed to ensure that training was provided to all staff who provided direct care to residents, including training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.
A) Review of the home's training manual related to the Personal Assistive Services Devices (PASDs), interview with the Director of Resident Care (DRC), and interview with the staff on the units confirmed that the home had not provided any training to the staff who applied PASDs or monitored residents with PASDs, including training in the application, use and potential dangers of the PASDs. r. 221. (1) 6. [s. 221. (1) 6.]

Additional Required Actions:

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

WN #6: 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).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The written plan of care for resident #900 did not set out clear directions to staff and others who provided direct care to the resident.
A) On an identified date in March 2014 a Personal Support Worker (PSW) provided care to resident #900 who was on isolation precautions without using a gown. The Personal Support Worker stated they did not know that the resident was on isolation precautions. There was an isolation cart outside the room and an isolation sign on the door. This resident, in addition to residents #901 and #902, was on isolation precautions and resided in a semi-private room which they shared with another resident. All three rooms had isolation carts and signs on the door. There was no direction in the rooms as to which resident required isolation precautions when providing care to the residents.
B) On an identified date in March 2013 the plan of care was reviewed for residents #901 and #902. The residents were on isolation precautions and had isolation carts in front of their rooms and isolation signs on the door. A PSW confirmed that staff should glove and gown when providing care to the residents. The written plan of care did not document that the residents were on isolation and that isolation precautions should be implemented when providing care. This was confirmed with a Registered Nurse who was unable to locate the written information on the plan of care that would provide direction to staff. [s. 6. (1) (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 with ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #7: 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. [O.Reg. 79/10, s. 8(1)(a)]
The licensee did not ensure that the Wound Care policy and procedure was in compliance with and was implemented in accordance with all applicable requirements under the Act.
A) The policy on Wound Care, section Skin Tears, No. 30-08-21, reviewed on February 27, 2014, did not specify that skin tears shall be assessed by the Registered Dietitian. The Assistant Director of Resident Care (ADRC) and registered staff confirmed that only skin tears that did not heal within seven days or became infected would be referred to and assessed by a Registered Dietitian. Regulation 50. (2)(b)(iii) requires, "Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a Registered Dietitian who is a member of the staff of the home." [s. 8. (1) (a),s. 8. (1) (b)]

2. [O.Reg. 79/10, s. 8(1)(b)]
Medication Administration policies were not complied with by staff administering medications at the breakfast meals March 7, 10, and 11, 2014.
A) The home's Medication Administration policy stated, "observe the resident taking all of the medications with water provided and never leave medication at side of bed, on table in dining room, at resident's side and always ensure they take the medication". Policy 30-10-01C Medication Administration stated, "Residents may self-administer medications only when specifically ordered by the attending physician in consultation with the care team. Registered staff are still responsible to ensure the medication is taken appropriately." (107)
B) At the breakfast meal March 7, 2014, residents #301 and #197 had pills left at the table for the residents to consume independently. The residents did not have an order for self administration of medications. (107)
C) The inspector found a pill on the floor outside the dining room at the breakfast meal

March 7, 2014. The RPN was unable to identify who the pill belonged to or where it came from. (107)
D) At the breakfast meal March 10, 2014 pills were left at the table with residents #230 and #302. The dining room was unattended by staff when the inspector noted the pills with the residents. Resident #302 was sleeping at the table with their pills on the table in-front of them and the dining room was unsupervised by staff. (107)
E) The RPN administering medications on March 10, 2014 stated the two residents self administered medications, however, the residents did not have a physician order to self administer medications and the medications had been provided from the medication cart. (107)
F) During the medication administration on March 11, 2014 between the hours of 0750 and 0845 the registered staff member checked medications against the Medication Administration Record (MAR) and signed medications before giving them to residents.

The Medication Administration Policy No. 30-10-01C, issued on 12/02/2014, stated "c. confirm the medications in the pouch are what is listed on the MAR sheet for administration at the time of this med pass...,
k. return to the Medication Cart and initial for the administration of each medication given BEFORE proceeding to the next resident. Where medications are refused or held, use appropriate numbered code on MAR sheet and chart on progress notes".
The registered staff member confirmed that they signed medications while checking them against the MAR, prior to providing the medications to the residents. (561) [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 with ensuring that where the Act of 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, is in compliance with and is implemented in accordance with all applicable requirements under the Act and is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that actions taken with respect to resident #401 under the Wound and Skin Care Program included documentation of all assessments, reassessments, interventions and the resident's responses to interventions.
A) Resident #401 had a physician's order that required wound care to be provided and monitored once per day. There was no documentation by the registered staff to indicate that this intervention was completed. The resident was also ordered other wound care treatments to be completed three times per day, however, the intervention was not documented as completed. In addition, the resident had another wound dressing and it was not documented by the registered staff as being completed. [s. 30. (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 with ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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. (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. O. Reg. 79/10, s. 50 (1).

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. [O.Reg. 79/10, s. 50(1)3]
Strategies were not in place to transfer and position resident #401 to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
A) Based on the resident's plan of care, resident #401 required a two person transfer with constant supervision to physically assist the resident using the mechanical sling lift for all transfer tasks. The staff employed the use of the ceiling lift for the resident's transfers. The manufacturers instructions for the BHM Medical Inc. Ceiling Lift System Operating Manual, March 2005, stated that it was very important to choose the right sling based on the needs of the patient to be transferred as well as their physical ability and size. There was no sling size noted on the resident's plan of care or in the health record. The resident had told staff that their back pain and blister on their back was from the sling digging into their skin. The registered staff documented in the progress notes that the open area on the resident was due to the use of the sling during transfers. The Personal Support Workers, Registered Nursing Staff and the Wound and Skin Care Specialist confirmed in an interview that the bruising on the

resident started with the sling being too small, causing friction and pressure on the resident's skin. The resident developed multiple pressure ulcers which continued to worsen, causing pain for the resident, and requiring medication. [s. 50. (1) 3.]

2. [O.Reg. 79/10, s. 50(2)(b)(i)]
The licensee did not ensure that residents #213 and #210, who were exhibiting altered skin integrity, including a skin tear, 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) A skin assessment was not completed for resident #213 for a cut sustained to the resident's cheek. On March 6, 2014 it was noted that the resident had a sizable (about 1 inch) cut on their cheek that was not there on March 4, 2014 when the inspector observed the resident. During interview, PSW staff identified the resident was cut during shaving on March 5, 2014, however, there was no documentation related to the cut in the progress notes, communication report or end of day reports and the Registered Nurse was not aware of the cut when interviewed on March 10, 2014. An assessment of the resident's skin in relation to the cut was not completed or documented. The home's wound care policy 30-08-05 stated "when a skin breakdown was discovered, it was to be reported immediately to the nurse-in-charge and would be included in the end of shift report. The-nurse-in-charge would complete an assessment of the area and initiate a plan of action." The home's policy "Documentation for Wound Care 30-08-08" stated that registered staff were to document findings of their assessments in the computerized progress notes. (107)
B) Resident #210, who was exhibiting altered skin integrity, including a skin tear, did not receive a skin assessment by a member of the registered nursing staff. On March 10, 2014, resident #210 was observed with a skin tear on the shin that was covered with dressing. An assessment had not been completed in the progress notes or Treatment Administration Record (TAR) as of March 10, 2014. Registered staff reported that there was no need for the Treatment Record- Weekly Assessment Summary tool to be filled out, however, the skin tear should have been added to the TAR.
On March 11, 2014 the Treatment Record - Weekly Assessment Summary tool for the skin tear was completed and placed in the TAR binder, however, there was no Treatment Administration Record for the skin tear. Another staff member confirmed that the TAR was not updated for this resident and proceeded to add the skin tear to the TAR.
The Assistant Director of Care confirmed that the Treatment Record-Weekly Assessment Tool should have been filled out by staff who assessed the resident, the

TAR should have been updated and the proper documentation should have been recorded in the progress notes and plan of care. (561) [s. 50. (2) (b) (i)]

3. [O.Reg. 79/10, s. 50(2)(b)(iv)]
Weekly skin assessments were not completed by a member of the registered nursing staff for Resident #401 when the resident was exhibiting altered skin integrity, including skin breakdown, and pressure ulcers.
A) Resident #401 was admitted from hospital to the home on an identified dated in October 2013. The assessment completed for the identified resident was that the resident was at risk for altered skin integrity, skin breakdown, skin tears or wounds, and pressure ulcers due to incontinence of bowel and bladder, psychotropic medications, acute renal failure, diabetes, and right sided weakness. The health record from the hospital used on admission to the home also stated the resident was on blood thinner medication twice daily. On admission, the resident had a skin tear on their forearm, an open blister on their back and a pressure ulcer on the sacral area. The home's Wound Care Program, Policy number 30-08-01 dated November 19, 2013, outlined that weekly skin assessment would be completed by the registered staff on all residents with impaired skin integrity. The weekly assessments were not completed consistently for this resident. There was no weekly assessment by the registered staff for the resident's open area on their back sacral and inner thigh. The resident's skin breakdown and pressure ulcers continued to worsen and a referral to a Wound and Skin Specialist was required. The resident had discomfort and pain with wound care and dressing changes. [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 with regulations, sections 50(1)3, 50(2)(b)(i), and 50(2)(b)(iv), 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. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 53(3)(b)]
The licensee did not ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's Responsive Behaviours Program, and the program was updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, and a written record was kept relating to the evaluation, which included date of the evaluation, names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.
A) The Director of Resident Care (DRC) and the Behavioural Support Officer (BSO) confirmed that there had not been an annual evaluation to determine the effectiveness of the licensee's Responsive Behaviours Program and there was no written evaluation report completed. [s. 53. (3) (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 with ensuring that at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, 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. [LTCHA, 2007, S.O. 2007, c.8, s. 57(2)]
The licensee did not respond in writing within 10 days to the Residents' Council related to concerns or recommendations from the Council about the operation of the home.
A) The Residents' Council minutes identified concerns related to noise levels within 1st Floor of the home and that this was a continuing concern. In addition, a concern was raised to change the lunch meal time from 12:00 to 12:30 pm. The written response from the Administrator was not received by the Residents' Council until several weeks later. In the minutes of January 20, 2014 concerns continued related to noise levels created by staff in the hallways, staff using their cell phones at the end of the hallways of the home, staff taking their breaks at the end of the hallways, staff continue to do their work during devotions, and meals being served very late especially on the weekends. A written response from the Administrator was received by the Council a month later addressing the concerns. In the minutes of February 24, 2014 the concerns identified related to the residents continuing to feel that there was some disrespect by staff during devotions. The members of the Council noted they would like all staff in the dining room and servery to stop what they are doing to provide quiet during devotions and to stop residents at the entrance of the dining room until the devotion is completed. The residents also identified several other concerns in the minutes. A response from the Administrator had not been received as yet by the Residents' Council. It was confirmed by the Administrator and the Director of Resident Care that the written responses were provided to the Residents' Council in preparation for the next monthly meeting and were not provided within 10 days. The President of the Residents' Council confirmed they received a response to their concerns in writing by the next Council meeting, but not within 10 days. [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 with ensuring 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 60(2)]
The licensee did not respond in writing within 10 days to the Family Council related to concerns or recommendations from the Council.
A) In the Family Council minutes of September 21, 2013 members identified concerns related to the television signals and channels in the home, the consolidation of additional services all in one bill, such as dental services, the need for more creative movement programs, lost versus stolen items and admission packages for the home. The written response from the Administrator was not received within 10 days by the Family Council, however a written response dated December 18, 2013 was reviewed at the next meeting of the Family Council. The minutes of June 22, 2013 were reviewed and members requested clarification related to Pet Therapy in the home, dog visitations, concerns raised such as oral care of residents, follow-up of charge nurses with management related to family concerns. A written response from the Administrator was not received by the Council within 10 days. A written response from the Administrator dated September 9, 2013 was received for review at the next meeting, a month later, dated February 21, 2014 addressing the concerns. In reviewing the minutes of November 16, 2013 a family member identified a concern related to dietary and family members support for Pet Therapy. A written response from the Administrator was not received within 10 days. A written response dated January 20, 2014 was received from the Administrator. [s. 60. (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 with ensuring if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Not all menu items were offered to residents according to the planned menu at the lunch meal March 5 and breakfast meal March 7, 2014.
A) The planned portion size was not followed by staff portioning the food at the lunch meal March 5, 2014. The planned portion for the Hutspot was 2 x #10 scoop, however, 2 x #8 scoop was used (larger); the planned portion of minced salad was 4 oz, however, a 2 oz portion was used; the planned portion for pureed apple braised pork was a #10 scoop, however, a #6 scoop was used (larger), the planned portion for savoury bread was 2 oz, however, a 1 oz portion was used (therapeutic extension menu stated "1 each", however, when sent to the floor the bread is no longer in individual pucks and portion size was not specified for bulk delivery).
B) The planned portion size was not followed by staff at the breakfast meal March 7, 2014. The planned menu required a #16 scoop for the pureed bacon, pureed assorted muffin and pureed bread, however, a #12 scoop (larger) was used for all items and a 5 oz portion of pea meal bacon was required for the minced texture, however, a 3 oz portion was used.
C) Staff confirmed what the pureed items were with the inspector. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #14: 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:
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. (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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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. [O.Reg. 79/10, s. 73(1)1]
The dining service did not include communication of the seven-day and daily menus to residents.
A) Menus were posted and communicated for the regular texture menu, however, daily and weekly menus were not communicated to residents requiring a pureed menu. The pureed menu varied significantly from the regular texture menu. The Nutrition Manager confirmed that the menus for the pureed texture were not communicated to residents. At the observed lunch meal March 5, 2014, staff were not able to identify the foods they were feeding to residents and did not communicate the menu to the residents they were assisting. [s. 73. (1) 1.]

2. [O.Reg. 79/10, s. 73(1)6]
Not all food and fluids were served at a temperature that was palatable to the

residents.
A) Residents on the first floor identified concerns about food temperatures to the inspectors during this inspection. Food temperature monitoring records required staff to serve foods at a minimum of 70 degrees Celsius, however, monitoring records for the fist floor dining area reflected foods were served at 61-65 degrees Celsius at the supper meal January 20, 2014 and 65-69 degrees Celsius at the dinner (lunch) meal January 27, 2014. Documentation did not reflect that action was taken to correct the low temperatures. The Nutrition Manager confirmed that food was to be served at a minimum of 70 degrees Celsius.
B) Food temperatures for the first floor dining area were not always taken/recorded as per the home's policy "Temperatures of Hot Food 75-07-12". Food temperatures were not recorded for the supper meals January 8, 27, 2014, or breakfast meals March 14, 17, January 6, 12, 14, 2014.
C) At the breakfast meal March 7, 2014 food was plated then placed on-top of the steam table waiting for staff to pick up the food and take it to the tables. Food sometimes sat for an extended period prior to staff delivery to the tables. [s. 73. (1) 6.]

3. [O.Reg.79/10, s 73(1)10]
Proper techniques were not used to assist resident #253 with eating at the lunch meal March 5, 2014.
A) Resident #253 had slid down in the chair and was leaning back with their head hanging off the back of the chair and staff continued to feed the resident while their head tilted back. The resident was noted to be coughing while being fed. The Nutrition Manager confirmed that the resident was to be seated in an upright position while being fed as it was a safety risk to feed the resident being fed with their head tilted back. [s. 73. (1) 10.]

4. [O.Reg. 79/10, s. 73(2)(b)]
Residents who required assistance with eating and drinking were served a meal prior to assistance being available at the breakfast meal March 7, 2014.
A) Resident #192 had food placed on the table prior to assistance being available. The resident sat not eating for over 10 minutes without staff available to assist the resident. The resident was sleeping at the table. Only one staff member was sitting at the table, however, five residents at the table required assistance with eating, as per their plans of care (#239, #272, #300, #244). All of the residents had food placed on the table and only one resident was being assisted (#272). Eventually three staff members came to assist the residents with eating.
B) Resident #206 sat in-front of their meal from the beginning of the lunch meal March

5, 2014 to 1255 hours without assistance or encouragement being provided. The resident's plan of care stated they required intermittent encouragement and physical assistance with eating. Staff sat down to assist the resident at 1300 hours, however, stated the resident was tired and did not want anything.
C) Resident #248 sat in-front of their lunch meal not eating on March 5, 2014 from the beginning of service until approximately 1300 hours without prompting or encouragement. The resident's plan of care required intermittent encouragement and physical assistance with eating. Staff sat down to feed the resident at 1300 hours. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with regulations, sections 73(1)1, 73(1)6, 73(1)10, and 73(2)(b), to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 87(2)(b)(ii)]
Procedures were not implemented for the cleaning and disinfection of resident personal assistance services devices and assistive aids.
A) During the inspection period several resident wheelchairs on both floors were soiled and not clean. Interview with the Director of Resident Care and review of the unit's daily cleaning schedule confirmed that staff were not consistently cleaning resident wheelchairs and that spot cleaning was not being done by the staff. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the implementation of procedures for the cleaning and disinfection of resident personal assistance services devices and assistive aides, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 91]
Hazardous substances were not kept inaccessible to residents at all times.
A) Hazardous chemicals were accessible to residents in the first floor shower room March 7, 2014 at 0828 hours. The door to the shower room was left propped open and the room and hallway were unattended by staff. The inspector was able to enter the room unnoticed and a bottle of Arjo Wipe Away cleaner (toxic symbol on label) was accessible to residents. Staff brought a resident into the shower room several minutes later and the inspector informed the staff of the accessible chemicals. [s. 91.]

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 with ensuing that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 99(b)]
The licensee did not ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.
A) The Director of Resident Care and Administrator confirmed that there had not been an annual evaluation to determine the effectiveness of the licensee's policy under Section 20 of the Act to promote zero tolerance of abuse and neglect of residents. [s. 99. (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 with ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 101(2)(c)(d)]
A documented record was not kept in the home that included the type and action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required and the final resolution, if any.
A) Minutes from the Dining Room Committee were recorded, however, a written response to concerns voiced in the meetings was not available. The Nutrition Manager confirmed that a written response to concerns raised at the meetings was not provided to residents, only a verbal response. A record was not kept identifying the type of action taken to resolve the concerns, including time frames for actions to be taken and any follow-up action required and the final resolution.
A) At the meeting February 3, 2014, residents voiced concerns about the taste of food, rushed meal service at the supper meal, tough meat, resident requests for meals/menu item changes. A written response to these concerns was not completed.
B) At the meeting January 6, 2014, residents voiced concerns about salads having too many big pieces of lettuce (ongoing issue), menu requests, fruits in fruit salad too hard to chew, chewy meat with too much fat. A written response to these concerns was not completed.
C) Staff confirmed that the Dining Room Committee was not a subcommittee of Resident's Council. [s. 101. (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 with ensuring that a documented record is kept in the home that includes, they type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required and the final resolution, if any, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 229(4)]
Staff did not participate in the implementation of the infection prevention and control program.
A) On Monday, March 10, 2014 the inspector observed a food service worker providing refreshments to residents. The food service worker went into resident #901's room, which was under isolation precautions, then left the room with an empty used cup and placed it in the bottom of the cart. The staff member did not use hand sanitizer or wash their hands. They then proceeded to resident #900's room, which was also under isolation precautions. They left the room and proceeded to the next resident room without using hand sanitizer or washing their hands. The written infection control policy stated that hands were to be washed after contact with items from the resident area for residents on isolation precautions.
B) On Monday, March 10, 2014 the inspector observed two Personal Support Workers providing care to resident #900 who was on isolation precautions. The two Personal Support Workers were not wearing gowns and left the room wearing gloves. A Registered Practical Nurse confirmed that the staff should wear gowns when providing care to the resident. The written infection control policy stated the staff should remove their gloves before leaving the resident's room.
C) Resident #232 was treated for a chest infection and was placed on antibiotics. The resident's name was not added to the infection control surveillance sheet as instituted by the home. On Thursday, March 13, 2014 at 1030, the inspector confirmed with a Registered Practical Nurse that this omission occurred. They stated that the nurse who had completed the orders should have written the resident's name on the tracking sheet. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #20: 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. [LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]
The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and acting on its results.
A) The President of the Residents' Council confirmed they had not participated in the development, carrying out and acting on the results of the satisfaction survey for the home. The Administrator and Director of Resident Care confirmed the Residents' Council had not participated in the development of the satisfaction survey and there was no findings in the minutes of the results being reviewed with the Council and acted upon.

The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and acting on its results.
A) A Family Council member confirmed they had not participated in the development, carrying out and acting on the results of the satisfaction survey for the home. The Administrator and Director of Care confirmed the Family Council had not participated in the development of the satisfaction survey and there was no findings in the minutes of the results being reviewed with the Council and acted upon. [s. 85. (3)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 129(1)(a)(ii)]
Drugs were not stored in a medication cart that was secure and locked.
A) A medication cart on the first floor was left unlocked and unattended on March 7, 2014 at 0940 hours. The inspector was able to open the drawers and access all of the medications in all drawers. The lock for the cart had been depressed, however, was not locking the drawers/cart. During interview the RPN stated the cart had been broken for several months and management was aware of the problem. They stated that the carts were not replaced as the home was going to transition to new carts for the new medication system in the future. The Director of Resident Care confirmed that new carts had been ordered, however, had not been implemented with action taken to mitigate risk while waiting for the new carts.
B) Replacement carts were received by the home on March 11 and 13, 2014. [s. 129. (1) (a) (ii)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #902	2014_207147_0006	147
O.Reg 79/10 s. 23.	CO #901	2014_207147_0006	147
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #001	2013_215123_0014	147

Issued on this 7th day of May, 2014

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

Laleh Nevell

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

Ministère 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) :	LALEH NEWELL (147), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2014_207147_0006
Log No. / Registre no:	H-000256-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 5, 13, Apr 7, 2014
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	FAITH MANOR NURSING HOME 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOHN KALVERDA

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall cease the use of any slings that pose a safety risk to residents and are not used in accordance with the manufactures' instructions while transferring residents.

Grounds / Motifs :

1. The licensee failed to ensure the staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

It was observed on March 5, 2014 at approximately 1400 hours that the buckle for the sling on a sit to stand lift on the first floor B wing was broken and posed a safety risk for residents. Interview with the Personal Support Worker (PSW) on the unit confirmed that the staff were using the lift for transferring the resident with the broken buckle and that the management staff were aware for the sling to be replaced.
Interview with the Maintenance manager, Maintenance supervisor and Assistant Director of Care (ADOC) confirmed that the home has placed an order for the replacement of the sling, however the new sling has not yet arrived and the staff have continued to use the broken sling.
(147)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall ensure steps are taken to minimizing the risk for all entrapment zones for the following beds: F204-1, F207-B and F125-A, to be complied with by Friday March 14, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. Bed F125-A failed the Joerns entrapment risk assessment for zones one and three on June 3, 2013. The bed on March 13, 2014 was not observed to have mattress keepers in place and the mattress had slid to the side of the bed frame, creating a gap approximately five to six inches between the right side rails and the mattress. A large gap approximately five and a half inches was also noted between the top and bottom bedrail.
The plan of care identified a bumper pad was required on the left bedrail, however, staff confirmed the bumper pad was not being consistently used as the resident would remove it.

B. Bed F204-1 had a large gap at the end of the bed, approximately five inches and another gap approximately three inches between the mattress and the quarter rails at the head of the bed on the right side. The bed had molded mattress keepers, however the mattress was too short for the bed frame and did not fit within the mattress keepers. The bed had passed the Joerns entrapment risk assessment of June 3, 2013, however the Director of Resident Care confirmed the bed had been replaced since the Joerns assessment and had not been assessed for safety since the replacement.

C. Bed F207-B failed the Joerns entrapment risk assessment for zones one and three on June 3, 2013. The bed on March 13, 2014 was observed to have a large gap, approximately three to four inches between the mattress and the left siderail. Interview with registered staff confirmed that the staff do not complete an assessment for bedrails unless they are considered a restraint. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2014

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall develop, submit and implement a plan to ensure all residents are assessed for the use of a PASD to assist in routine activities of daily living, alternatives to the use of the PASD has been considered, the use of PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

The compliance plan is to be emailed to Laleh Newell - Nursing Inspector at Laleh.Newell@ontario.ca by April 4, 2014.

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 33(4)]
Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD, the use of the PASD was reasonable given the resident's condition, consent was obtained, and the device was approved.
A) During interview resident #204 confirmed that the use of two quarter rails while they were in bed was for the purpose of a PASD to assist the resident with bed mobility and safety. The health records did not include an assessment identifying that alternatives were tried prior to the use of the bed rails. Interview with the registered staff and the Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.
B) Resident #216 used one quarter and one half rail when in bed as a PASD to assist with bed mobility. The health records did not include an assessment identifying that alternatives were tried prior to the use of the bed rails. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.
C) Resident #232 used one full bedrail while they were in bed as a PASD to assist with bed mobility. The health records did not include an assessment identifying alternatives were tried prior to the use of the bed rails. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from

the resident for the use of the PASD.
D) Resident #192 used a seatbelt while in their wheelchair as a PASD for safety. Interview with the registered staff and Personal Support Worker (PSW) confirmed that the resident was able to undo the seatbelt and it was used for safety and comfort while the resident was in their wheelchair. The health records did not include an assessment identifying alternatives were tried prior to the use of the seatbelt. Interview with the registered staff and Assistant Director of Resident Care (ADRC) confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is to develop, submit and implement a plan to ensure all mechanical lifts and slings are kept in good repair, maintained and cleaned at the level that meets manufacturer specifications.

The plan is to be submitted via email to Laleh Newell - Nursing Inspector - at Laleh.Newell@ontario.ca by April 4, 2014.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 90(2)(a)]
Procedures were not developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.
A) On March 5, 2014 two mechanical lifts on the 2nd floor were not kept in good repair and maintained at a level that met manufacturer specifications. Review of the home's operating and product care instruction for the Medi-Lifter 4 – Total lift, indicated that the home's personnel in charge of the maintenance and safety inspection of the patient handling devices were to conduct and complete a monthly inspection details form and if any devices were noticed to be defective, they must replace it with an original component.
The two mechanical lifts were observed to have duct tape around the pivot of both lifts. Interview with the home's Maintenance Manager confirmed that the home had not been consistently conducting regular maintenance checks on all the mechanical lifts in the home as the home was no longer utilizing an external company for these audits and had been conducting the maintenance checks of the mechanical lifts internally.
Review of the home maintenance logs also confirmed that these maintenance checks were not being conducted on a consistent basis to ensure all components of the lifts were in good repair and maintained at a level that met the manufacturer specification.
B) It was also noted on March 5, 2014 that the slings used for most of the mechanical lifts on both floors were frayed, torn or damaged.
Review of the home's operating and product care instruction for the Medi-Lifter 4 – Total lift, indicated that the staff were never to use damaged, torn or frayed slings.
Interview with the Maintenance Manager and ADRC confirmed that the home had been aware of these frayed and torn slings and new slings had been ordered, however the slings were not taken out of service and staff continued to use the frayed slings for resident transfers while awaiting delivery of new slings.
r 90. (2) (a) (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall develop, submit and implement a plan to ensure that all staff who provide direct care to the residents are trained related to the use of PASDs, monitoring residents with PASDs, training in the application, use and potential danger of the PASDs.

The plan is to be submitted electronically to Laleh Newell - Nursing Inspector at Laleh.Newell@ontario.ca by April 4, 2014.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 221(1)6]
The licensee failed to ensure that training was provided to all staff who provided direct care to residents, including training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.
A) Review of the home's training manual related to the Personal Assistive Services Devices (PASDs), interview with the Director of Resident Care (DRC), and interview with the staff on the units confirmed that the home had not provided any training to the staff who applied PASDs or monitored residents with PASDs, including training in the application, use and potential dangers of the PASDs. r. 221. (1) 6. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee prepare, submit and implement a plan that ensures 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; and (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
The plan is to be emailed to Laleh Newell - Nursing Inspector at Laleh.Newell@ontario.ca by April 4, 2014.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, not all bed systems were evaluated in accordance with evidence-based practices to minimize risk to residents.
A) The home commissioned an external contractor to complete a bed entrapment zone audit of all the resident bed systems on June 3, 2013. The results of the audit concluded that over 47% of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. Since that time, the management of the home have not instituted measures to minimize or mitigate potential risk to many of those residents.
B) During a tour of the home, some gaps between head boards and mattresses, between the top and bottom bed rails and between bed rails and mattresses were observed. These were areas that failed bed safety parameters during the audit or beds that were changed after the audit without a re-assessment of the safety zones. The home had a mix of bed models and mattresses of different ages. Some beds were furnished with quarter length assist bed rails and others with older full length rails. Bed mattresses were noted to be too short for the bed frames. Mattresses that were too short created excessive gaps at the head or foot of the bed (entrapment zone 7). A number of bed frames had missing mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed.
C) At the time of this inspection, many of the failed beds continued to be used by residents who used bed rails. Since the audit, some new mattresses and bed frames had been purchased, however the management did not identify or document which beds they replaced or were applied to. The beds that received a new mattress also did not receive a post entrapment zone assessment to determine if the new mattresses were adequate for the specific bed frame. (107)

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

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

and the Director

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

Ministère 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 5th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Laleh Newell

Name of Inspector / Nom de l'inspecteur : LALEH NEWELL

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