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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2015;	2014_347197_0008 (A1)	O-000279-14	Resident Quality Inspection

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street Stouffville ON L4A 4J3

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

FRIENDLY MANOR NURSING HOME
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

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JESSICA PATTISON (197) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The inspection and order reports have been amended to reflect an updated compliance date of July 31, 2015 for compliance order #002 related to lighting, as requested by the home.

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

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

JESSICA PATTISON (197) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 7-11, 14-17, 22, 2014

A Critical Incident Inspection was done concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Nursing, the Assistant Director of Nursing, the Food Service Supervisor, the Registered Dietitian, the Activation Supervisor, Registered Nurses, Registered Practical Nurses, a Pharmacist, a Physiotherapy Assistant, maintenance staff, housekeeping staff, activation staff, Health Care Aids/Personal Support Workers, the Resident Council President, residents and resident family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care and services including medication pass, dining service and activation, reviewed resident health care records and policies including those related to abuse, infection prevention and control, activation, medication, responsive behaviours and pest control and measured lighting levels in the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

18 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(e) in that the resident-staff communication and response system is not available in all areas accessible by residents.

The following areas that are accessed by residents were observed to be without a resident-staff communication and response system:
- the hair salon
- the small lounge adjacent to the main entrance door that is identified as the waiting area

The lack of a resident-staff communication and response system in resident areas is a potential risk to the health, comfort, safety and well being of residents who may not be able to obtain assistance when required. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 18 in that the lighting requirements as stated above are not being maintained in the home.

On specified dates, illumination levels in residents' bedrooms and bathing rooms were checked by Inspector #102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available functional electric light fixtures turned on. Window coverings were closed and privacy curtains were open, where provided, when light levels were measured.

Levels of illumination in the majority of residents' bedrooms were less than the required lighting level of when measured one or more meters away from wall mounted light fixtures.

The level of illumination provided in the tub and shower room is less than the required lighting level within the shower and in the vicinity of the toilet and sink.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 3 (1)1 in that residents were not treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On a specified date, Inspector #197 and #531 observed two Health Care Aids (HCA's) charting in the food and fluid intake binders during the resident's lunch meal. One HCA had his/her binder on table four in-between two residents who require some feeding assistance and still had food in front of them. Another HCA had his/her binder open on a resident's wheelchair tray and was charting in-between giving the resident bites of pudding and was not interacting with the resident.
On two others specified dates, Inspector #197 observed a HCA charting on a resident table in front of residents that were still eating and required partial assistance.
During an interview with the Assistant Director of Nursing (ADON), she stated that staff are not supposed to do their charting until all residents are done or almost done eating and confirmed that they are not to chart while residents still require assistance with their meals.

On a specified date at the breakfast meal, Inspector #531 observed a Personal Support Worker student who was feeding Resident #6329. The student wiped the resident's mouth with his/her fingers instead of using the napkin and then wiped his/her fingers on their uniform.

Inspector #197 observed this home to use 3 semi-circle tables for residents who require partial or total feeding assistance. These tables can seat up to 4 residents per table and are set up so that these residents face the wall. These tables do not provide

a respectful and dignified dining experience for residents, as they do not recieve the opportunity to face and interact with co-residents. [s. 3. (1) 1.]

2. The licensee has failed to comply with LTCHA 2007, s.3(1)8 in that residents were not afforded privacy in treatment and in caring for their personal needs.

On a specified date, Inspector #531 interviewed Resident #6291. During this interview a staff member entered the resident's room without knocking or requesting permission from the resident. The resident shared with the Inspector that this happens often at the home.
On a specified date, Inspector #197 interviewed Resident #6328. During this interview the resident's door was closed and a staff member entered the resident's room without knocking or requesting permission to enter.
On another date, a Health Care Aid, an Activation staff member and a Restorative Care staff member walked into a resident's room during a resident interview, without knocking, or requesting permission to enter the resident's room. The resident became frustrated with the interruptions and shared with each person that this was not a good time as he/she was having a meeting.

On a specified date, Inspector #531 observed two Health Care Aids (HCA) assisting Resident #6305 from the dining room to the bathroom in his/her bedroom. The HCA's entered the resident's bathroom and transferred the resident onto the toilet leaving both the entrance door to the room and bathroom door open. The two HCA's then left the room to attend to other tasks leaving both doors opened.
Inspector #531 observed both HCA's to return with a mechanical lift and transferred the resident from the bathroom. Both doors remained open during the transfer.

On a specified date, during an interview with the Assistant Director of Nursing and the Administrator, it was confirmed that staff are expected to provide residents with privacy when entering resident rooms and providing care to residents. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes residents' individuality and respects residents' dignity and that every resident is afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, s.6(1)(a)(b)(c) in that they did not ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident, (b) the goals the care is intended to achieve, and (c) clear directions to staff and others who provide direct care to the resident.

Resident #6319's care plan, progress notes and activity documents were reviewed and they indicated that there was no program, no individualized goal and no interventions for this resident related to activities.

In an interview with staff member #S100, he/she indicated that there were no official programs for cognitively impaired residents, including Resident #6319. Staff member #S100 stated that he/she uses the flow sheets to decide which residents to provide 1:1 visits. There is no record of Resident #6319 being involved in 1:1 visits and nothing noted in the resident's plan of care.
Throughout the inspection, Resident #6319 was observed wandering in and out of other resident rooms.

Resident #6286's care plan was reviewed and states that the resident has specific behaviours. The plan of care directed staff to discuss with the family any past history and successful coping mechanisms. The current plan of care does not mention the resident's past history or successful coping mechanisms and does not list any other interventions to address the behaviour. [s. 6. (1)]

2. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in a resident's plan of care was not provided as specified in the plan.

On a specified date, at approximately 1100 hours, Inspector #197 walked by the North Lounge and noticed that Residents #6319 and #6302 were in the lounge with their drinks spilled on the floor and on their clothes. There was no staff present monitoring or assisting the residents. Inspector #197 notified the Administrator, who then took action.

This was the second time during the inspection period that the Inspector witnessed Resident #6319 unattended and with his/her drink spilled.

The current care plan states that Resident #6319 requires feeding assistance at meals and snacks.

The ADON was interviewed and confirmed that Resident #6319 should be supervised when eating and drinking. [s. 6. (7)]

3. The licensee has failed to comply with the LTCHA 2007, s. 6(10)(b) in that they did not revise the plan of care when interventions were no longer necessary.

A review of the current care plan indicated that Resident #6286 has specified behaviours.
In an interview with the ADON, the Administrator and staff member #S101, they

indicated that Resident #6286 is no longer having this specified behaviour and that the care plan does not reflect the residents present status related to responsive behaviours. Also, in an interview with staff members #S102 and #S103, they indicated that the resident has not exhibited these behaviours to staff or other residents. Throughout the inspection period there were no indications of this specified behaviour from Resident #6286. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written plans of care set out the planned care for residents, the goals the care is intended to achieve and clear directions to staff. This plan should also ensure that the plans of care are reviewed and revised when the care set out in the plan is no longer necessary and that care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, s. 10(2) in that they did not include services for residents with cognitive impairments in their recreational and social activities program.

Review of the current care plan for Resident #6319 indicated "Activity as Tolerated" as

the intervention under the activities section.

Review of the Activity Calenders for February, March and April, 2014 revealed few activities for cognitively impaired residents.

Progress notes revealed that there was no structured programming for Resident #6319 from January 6, 2014 until April 14, 2014.

Resident #6319's family member stated during the family interview that the resident did not attend activities.

During Inspector observations from April 7-11 and 14-16, 2014, Resident #6319 was not involved in activities.

During the period of April 7-11, 14-17 and 22, 2014, Inspector #531 observed the following related to activities for cognitively impaired residents, including review of the Activity Flow Sheets:
- Residents observed were #6325, #6293, #6306, #6316 and #6287
- April 7- 11th, 2014, Inspector #531 observed the residents listed above resting in bed or a chair in their rooms after breakfast, lunch and on April 9th after dinner. Inspector #531 did not observe the above residents involved or taking part in any type of activity program.
- Review of the activity flow sheets from February - April 12, 2014 confirm the residents participated in the following:
- Resident #6325, was documented to participate in sing song events on three dates with the remainder documented as resting or sleepy
-Resident #6293 was documented to be watching TV either in his/her bed or in the TV lounge and attended music events on two dates
-Resident #6306 was documented to have 1:1 feet/hands x 15 minutes X1, attend music on three dates and for the remainder, wandering in the hall, sitting in the corridor, front sun room or tv activity room
-Resident #6316 was documented to attend music on three dates, hairdresser X1, other activities described as sitting in the corridor with another male resident or wandering
-Resident #6287 was documented to attend music events on three dates and other activities were documented as resting or bed.

In an interview with the Activity Supervisor, staff member #S104, she was unable to provide evidence of programming for cognitively impaired residents. [s. 10. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the recreational and social activities program for the home includes services for residents with cognitive impairments, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 15(2)(a)&(c) in that resident care equipment was not kept clean and the home, furnishings and equipment were not kept in a safe condition and good state of repair.

A resident's walker was observed on April 7, 2014 in the dining room to have visible dirt and debris in the holes on top of the walker. This walker was observed again on April 17, 2014 in the same condition.

A resident's wheelchair was observed on April 8 and 11, 2014 to be visibly dirty with food particles inside the wheels and the side protective cushions were covered in a

white film. This wheelchair was observed on April 17, 2014 and the food particles inside the wheels were gone, but there was still a white film on the side protective cushions.

A hoyer lift was observed on April 9, 11 and 17, 2014 with visible dirt and debris on the foot rest.

Inspector #197 interviewed the ADON in relation to the cleaning of resident care equipment. She stated that Health Care Aids on the night shift are supposed to clean resident's wheelchairs, walkers and lifts and she provided a copy of the nightly cleaning duties. The ADON also provided lists of wheelchairs cleaned on April 15 and 16, 2014, but did not have any further records to show that lifts and/or resident walkers were being cleaned. The list for April 15, 2014 did show that the resident's wheelchair noted above had been cleaned. When the inspector asked the ADON if the side protective cushions on the resident's wheelchair could be cleaned, she stated that yes they could and that the home had purchased a steamer for this purpose. The ADON agreed that it did not appear that these side cushions had been cleaned. [s. 15. (2) (a)]

2. During the inspection of the home on April 14 and 15, 2014 by Inspector #102, the following was observed:

- Ceiling tiles stained and/or damaged in many resident areas
- A number of ceiling tiles are missing in the laundry room and in the service area corridor. Staff confirmed that the roof had leaked through the ceiling surface in these areas. The plastic vapor barrier that covers the fiberglass insulation within the ceiling space on the underside of the roof deck above the laundry room is discolored and stained; the fiberglass insulation is also visibly discolored. Moisture infiltration of building materials presents a potential risk of harm from mold growth.
- The finish was worn from the surfaces of wood table tops in the dining room
- Painted surfaces of wooden captain's type chairs in the dining room are scraped, chipped and/or worn
- Surface veneer is peeling and missing from the top surface edges of several bed side tables and from the edges of drawers on many bed side tables in residents' bedrooms exposing composite wood subsurface. Worn surfaces are not moisture resistant and can not be adequately cleaned and disinfected, as needed, presenting a potential infection protection and control risk.
- Plastic film was in use over 1 large south facing window in the dining room and 2 of 4 south facing windows in bedroom 214. In bedroom 214, 1 of the windows had an

open window pane behind the plastic film. The open pane was identified by staff to have been "stuck" in the open position prior to the application of the film. Cold air draughts from windows are a potential risk to the comfort and well being of residents.
- A number of wall mounted bedroom lights were noted to have one of two bulbs not functional. Several wall mounted light fixtures in bedrooms were not functional due to missing switches.
- One 2 by 4 florescent ceiling light fixture in the dining room was missing a cover.
- Painted surfaces were scraped and/or gouged: room 211's washroom door frame, walls in washrooms in 232, 239; wall surfaces under the windows in room 219; door to washroom in 219
- Awning type windows were missing the handles in a number of bedrooms: 237, 239, 240, 242
- Several washroom doors were misaligned and would not close fully: room 210, 203

Floor tiles are cracked, chipped, misaligned and/or lifting on edges in a number of resident areas including: several bedrooms and ensuite washrooms; the dining room; sections of corridor.
Non intact floor surfaces can not be thoroughly cleaned; uneven, not level floor surfaces may place residents at increased risk for falls and present mobility challenges. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 65(2)(b) in that they did not ensure that the recreation and social activities program includes activities in the evening.

During an interview on a specified date, Resident #6305 indicated that there were no activities on weekends and evenings and that no activities in the evening made for a long day.

Review of the Monthly Activity Calender for February, March and April 2014, indicated that the latest scheduled activity for each day was 2:00 p.m. with the exception of one day each month. On this one day per month, a Crock Pot Dinner is scheduled for 5:00 p.m. for residents that participated in preparing the meal earlier in the day. This Crock Pot Dinner would be the resident's dinner meal and the activity of putting the meal together would have occurred during the day. [s. 65. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that recreation and social activities are offered to residents in the evenings, to be implemented voluntarily.

WN #8: 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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)11 in that comfortable dining room chairs are not provided to meet the needs of all residents.

During dining observation on April 7, 2014, Inspector #197 observed hard, wooden chairs to be used for all residents other than those in wheelchairs. Some chairs appeared to have cushions, but others did not.

During the lunch meal on a specified date, Inspector #197 interviewed Resident #2. This resident stated that he/she brings their own cushion to the dining room each day because the chairs are so uncomfortable and that he/she has a bad back. The resident also stated that he/she would not leave the cushion in the dining room otherwise it would go missing. [s. 73. (1) 11.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that comfortable dining chairs are provided to meet the needs of all residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.86(2)(b) in that measures were not taken to prevent the transmission of infections.

During the inspection of the home on April 14 and 15, 2014, the following observations were noted as potential cross-infection risks to staff and residents:
-urine output containers, unwrapped rolls of paper towels and toilet paper stored on toilet tanks in residents' washrooms
-soiled pull cords for over the bed light fixtures
-soiled activator cords adjacent to toilets for the resident-staff communication and response system
-in the bathing room adjacent to room 241, the shower chair remained visibly soiled for 2 days. Soiled facecloths were left on the shower chair and hanging on the shower grab bar. It was confirmed that the shower is used by at least one resident.
-multi use equipment including lifts and infection control supply units are stored in the bathing room adjacent to room 241. The shower, the sink and the toilet are used. (102)

During stage 1 observations, Inspector #197 observed multiple soiled call bell pull cords in resident bathrooms. [s. 86. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that measures are in place to prevent the transmission of infections, to be implemented voluntarily.

WN #10: 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. The licensee has failed to comply with O. Reg. 79/10, s. 229(4) in that all staff do not participate in the implementation of the infection prevention and control program.

On a specified date, Inspectors #197 and #531 observed the lunch meal. During this observation a food service worker, who was not wearing gloves, was observed serving ice cream directly from the pail, rubbing his/her nose and lips, licking their fingers and continuing to serve residents without stopping to wash his/her hands.

On an identified date, Inspector #571 observed a staff member coming out of resident room 222 carrying a soiled incontinent product against his/her uniform supported between their bare left arm and left side of their uniform top. The same staff member and a Personal Support Worker student were then observed changing the incontinent brief of a resident who was isolated for MRSA. The staff member and student were not wearing protective gowns. Personal Protective Equipment (PPE) was available at the door with signage "to see nurse at the desk before entering".

Throughout the inspection, five rooms with isolated residents had proper PPE in carts outside of room but there was no signage up to indicate what kind of precautions staff are to take as per Home Policy # ICD C-2.

On a specified date, Inspector #571 observed staff wheeling soiled linen/garbage carts up the halls and resting them against carts containing clean items such as the ceiling lift and lift sheets.

On an identified date, inspector #571 observed three piles of dog feces in the front lounge which is accessed by residents.

Numerous staff members were observed moving soiled linen/garbage carts in the hallways with bare hands without washing their hands afterward. When staff are disposing of soiled linen/garbage their contaminated gloves come into contact with these same carts. [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 to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 5 in that a room accessible to residents was not a safe and secure environment.

During the inspection on April 14, 2014, Inspector #102 observed that the Thermopatch high heat label applicator was left on and was not under supervision by staff in the residents' Bayview Lounge, placing residents at potential risk for burns. [s. 5.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)2 in that a door leading to a non-residential area was not equipped with a lock to restrict unsupervised access by residents when they are not supervised by staff.

The corridor separation doors leading to and from the service wing area are not equipped with locks to restrict unsupervised access by residents.
On April 14, 2014 at 11:20 am, 2 doors leading into the laundry room were unlocked and the room was not under supervision by staff. Hazardous products are located within the room; the door leading into the servery was not locked. Hazardous products were located in an unlocked under sink cupboard.

Noted that the separation doors are connected to a keypad which is connected to a door alarm system. [s. 9. (1) 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 13 in that a resident bedroom occupied by two residents did not have sufficient privacy curtains to provide privacy.

Privacy curtains were not sufficient to ensure privacy to each of the two residents in a specific room. The ceiling lift track obstructs the tracks for the curtains leaving a gap of approximately one meter at each bed. [s. 13.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 22. Every licensee of a long-term care home shall ensure that all plumbing fixtures in the home with hose attachments are equipped with a back flow device. O. Reg. 79/10, s. 22.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 22 in that a plumbing fixture in the home with a hose attachment was not equipped with a back flow device.

A back flow device is not provided on the hose attachment at the sink in the hair salon. [s. 22.]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, s. 24(1) in that they did not immediately report a suspicion of staff to resident neglect that resulted in a risk of harm to a resident, and the information upon which it is based, to the Director.

On a specified date, a resident was discovered by day staff shortly after shift change, lying in bed with soiled wet linen and clothing, wearing a winter coat.

In an interview with the ADON on April 22, 2014, she confirmed that this incident of neglect was not reported to the Director until four days after it has occurred. [s. 24. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 71(4) in that not all planned menu items were offered and available at each meal.

From March 31 to April 17, 2014 there were ten dessert substitutions, two breakfast meal substitutions and two lunch meal substitutions. On April 16, 2014 there was no mixed greens salad served as per the planned menu and there was no substitution provided to residents. This was confirmed in an interview with the Food Service Supervisor on April 16, 2014.

Inspector #531 interviewed a resident on April 22, 2014. During this interview the resident stated you are never sure what you are going to get at meal time. [s. 71. (4)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 72(3)(a) in that foods were not served using methods to preserve appearance and food quality.

On a specified date, a food service worker was observed to be serving food from the hot food cart. The food service worker was not wearing gloves and was serving grilled cheese sandwiches and at the same time scooping out pickles to put on resident plates with her bare hands. The food service worker did not wash her hands in-between touching the pickles and the grilled cheese sandwiches.

During an interview with the Food Service Supervisor, she stated that staff can use their bare hands, if washed first, to serve foods such as sandwiches, but that foods such as pickles should be served with a scoop.

On another date, Inspector #531 observed food service workers to serve the last few tables at the breakfast meal by stacking the plates on top of each other to save time. This meant that the bottom of each plate was touching the food on the plate below and potentially altering the appearance of food served to residents. [s. 72. (3) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 97(1) in that a resident's substitute decision-maker was not notified within 12 hours upon the licensee becoming aware of an alleged incident of neglect involving a resident.

On a specified date, an incident of neglect was reported to the Director involving a resident.

In an interview with the ADON on April 22, 2014, she stated that the resident's substitute decision-maker was not notified of the incident of neglect within the 12 hour time period. [s. 97. (1) (b)]

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PATTISON (197) - (A1)

Inspection No. / No de l'inspection : 2014_347197_0008 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000279-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Jan 30, 2015;(A1)

Licensee / Titulaire de permis :
MANORCARE PARTNERS II
6257 Main Street, Stouffville, ON, L4A-4J3

LTC Home / Foyer de SLD :
FRIENDLY MANOR NURSING HOME
9756 County Road, #2, P.O. Box 305,
DESERONTO, ON, K0K-1X0

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debbie Long

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To MANORCARE PARTNERS II, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee will ensure that the resident-staff communication and response system is provided in all areas that are accessible to residents.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The resident-staff communication and response system is not available in the following areas that are accessible by residents:
- the hair salon
-the small lounge adjacent to the main entrance door that is identified as the "waiting area".

The lack of a resident staff communication and response system in resident areas is a potential risk to the health, comfort, safety and well being of residents who may not be able to obtain assistance when required. (102)

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

Jul 25, 2014

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

(A1)
The licensee will ensure that required levels of lighting are provided in all areas
of the long term care home including:
• A minimum of 215.28 lux of continuous consistent lighting in corridors;
• A minimum level of 215.28 lux in all residents' bedrooms, program lounge space, dining areas, washrooms and tub and shower rooms.
The licensee will provide a written progress report to indicate the status of the
correction of the lighting levels by October 10, 2014.
This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. On April 14 and 15, 2014 illumination levels in residents' bedrooms and bathing rooms were checked by Inspector 102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available functional electric light fixtures turned on. Window coverings were closed and privacy curtains were open, where provided, when light levels were measured.

Levels of illumination in the majority of residents’ bedrooms were 50% or less of the required lighting level of 215.28 lux when measured one or more meters away from wall mounted light fixtures.

The level of illumination provided in the tub and shower room located adjacent to room 241 is less than 50 per cent of the required lighting level of 215.28 lux within the shower and in the vicinity of the toilet and sink.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life.
(102)

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

Jul 31, 2015(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 30 day of January 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PATTISON - (A1)

Service Area Office /
Bureau régional de services : Ottawa