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 sous *la Loi de 2007 sur les foyers de soins de longue durée***

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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 19, 2019 | 2019_787640_0017 | 030326-18, 032624-18, 000994-19, 010063-19 | Complaint |

### Licensee/Titulaire de permis

Golden Dawn Senior Citizen Home
80 Main Street Lion's Head ON N0H 1W0

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

Golden Dawn Nursing Home
80 Main Street Lion's Head ON N0H 1W0

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

HEATHER PRESTON (640)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): May 21, 22 and 23, 2019.**

**During the course of the inspection, the LTCH Inspector toured the home, interviewed residents, SDMs and staff, reviewed policy and procedure, observed staff during the provision of care and service and dined with the residents.**

**During the inspection, the following complaints were reviewed:**

**Complaint log #010063-19 related to staffing concerns**
**Complaint log #000994-19 related to food production, dining and snack service**
**Complaint log#032624-18 related to a rate reduction concern**

**The following follow-up inspection was conducted:**

**Log #030326-18 related to CO #001 from inspection #2018_580568_0017, related to S. O. 2007, s. 8 (3) related to the requirement for 24/7 RN on site.**

**During the course of the inspection, the inspector(s) spoke with residents, Resident's Council President, Family Council Recorder, SDMs, support aids (SA), personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Cook, Kitchen Aids, Student Kitchen Aids, Public Health Inspector, Staffing Co-ordinator, Administrative Assistants, Activities Manager, Director of Care (DOC) and the Administrator.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Food Quality**
**Medication**
**Resident Charges**
**Sufficient Staffing**
**Training and Orientation**

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

**10 WN(s)**
**5 VPC(s)**
**4 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2018_580568_00017 regarding S. O. 2007, s. 8 (3), with a CDD of January 11, 2019, wherein the home did not have an RN on duty and present in the home at all times.

The LTCH Inspector reviewed the RN schedules from January 28, 2019 up to and including May 14, 2019. There were 12 occasions where an RN who was a regular member of the nursing staff, was not present in the home. Three occasions were related to severe weather. On one occasion there was an RN in the building, however RN #118 had been hired the previous day and had not completed mandatory training or any orientation to the home and the duties of the RN.

RPNs #100 and #105 said they had been left in charge of the building without an RN on site on a few occasions. RPN #105 was hired in March of 2018 and said they used to be scheduled for night shift without an RN on site. RPN #100 said they worked a night shift approximately two weeks ago without an RN on site.

The DOC reviewed the schedule and stated the dates identified did not have an RN on site. The Administrator was not aware there had been an issue with the RN staffing.

The Administrator provided documentation about RN job postings to include Indeed and the home's website. They stated they struggle to compete with other home's pay rates and the location of the home is difficult for many potential candidates. They had four RNs accept employment. Two remain, one attended the home for two shifts then left and another did not show up for their orientation.

The DOC acknowledged the home had not ensured there was always an RN, who was a regular member of the nursing staff, on site at all times. [s. 8. (3)]

***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. 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,**
**(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all foods in the food production system were stored using methods to prevent adulteration, contamination and food borne illness.

During a complaint inspection regarding food quality, the LTCH Inspector interviewed a member of Resident's Council. During that interview, they said that the home kept the leftover food from the served meals and served them at a later date.

The LTCH Inspector observed a complete dinner service during their inspection. They observed a dietary staff member deciding which leftover food items in the steam table had enough to save and re-use. The dietary staff member stated they re-purposed the leftovers from the steam table when there were enough to do so. They put the item in a storage container, left it on the counter in the kitchen for various periods of time, then labeled it and placed it in the freezer.

Dietary staff #103 said they do not take any temperatures of the food during the cool down period. They just knew how long the item should sit before going into the freezer.

The licensee's policy "Use of Leftover Foods", policy #B.9 with a revised date of July 2014, directed staff that following meal service, any foods that had been served to residents were to be discarded. It directed that food that was leftover was only considered suitable to be retained and used again for residents if the product had been held at a safe temperature, the holding time had not exceeded acceptable limits and the quality had not deteriorated.

The LTCH Inspector interviewed the home's local public health inspector who stated that any food that had been in the steam table was not to be saved and re-used by any

means.

During observation of the freezer, the LTCH Inspector observed more than 40 containers of frozen food items. All labeled, some without a date and a couple dated from March 26, 2019. The containers were previously used margarine tubs, ice cream and yogurt containers and various others. On the freezer door, dietary staff #107 pointed out a list the staff kept when they placed leftovers in the freezer. The list contained approximately 68 items categorized under beef, liver, pasta, pork, chicken/turkey, fish, lamb, vegetables, soups and other food items. None of the named items on the list had a date associated with them.

The licensee failed to ensure that all food items were stored to prevent adulteration, contamination and food borne illness. [s. 72. (3) (b)]

***Additional Required Actions:***

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

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**WN #3: 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: 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

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

During a complaint inspection regarding food quality, menu items and food temperatures, the LTCH Inspector interviewed a member of the Resident's Council. They stated the food was often cold and had poor flavour. They said they no longer had the hot meal at breakfast as it was "always" cold. They said that the vegetables were nearly always cold. You could not even melt butter on them they were so cold. They very seldom had flavour.

Resident's Council discussed food temperatures and poor food quality on September 10 and November 7, 2018 and January 14, 2019.

Family Council discussed continuing concern about the quality of meals for the residents on December 19, 2018.

The home's policy "Food Service Temperatures", policy #D.2 with a revised date of July 2014, directed staff to take food temperatures in the centre of the thickest part of the food, when cooking, chilling, hot-holding or reheating all food products. All designated dietary staff members record all hot food temperatures on completion of the cooking process, on the Food Temperatures Recording chart and initial the entries. A Food Temperature Recording Chart was also completed for all hot menu items and for cold foods in the serveries prior to meal service. Hot foods must be held at a minimum temperature of 60 degrees C (140 F) and may be held a maximum of two hours.

During the inspection, the LTCH Inspector observed the supper meal from beginning to end. They tasted each of the items and found the flavour was basic but not offensive to the Inspector. The mixed vegetables were cool.

The LTCH Inspector observed dietary staff #103 taking food temperatures of all foods being held in the steam table, using an Infrared thermometer. When asked, they stated they were informed to use this tool by their previous manager as it was smarter than the other type.

The cook documented entrée #1 to be 179.2 degrees Fahrenheit (F) using the infrared thermometer. The LTCH Inspector's internal probe thermometer read 93.7 Celsius (C) which converted to 200.66 degrees F temperature. The mixed vegetables, using the infrared thermometer was documented by the cook to be 156.7 degrees F. The LTCH Inspector's internal temperature probe was 87.8 C which converted to 190.4 degrees F both outside the home's acceptable high temperature range of 170 degrees F.

The served food temperatures were taken, by the LTCH Inspector using the internal temperature probe, from a resident's meal. Entrée #1 was 87 degrees C and the mixed vegetables were 50.8 degrees C. This was a loss of 6.7 degrees C for the entrée and 37 degrees Celsius for the mixed vegetables from temperatures taken at the steam table to when the meal was served to the resident.

Dietary staff #103 and #107 told the LTCH Inspector they used the infrared thermometer to check the food temperatures using the Fahrenheit temperature scale. Dietary staff #119 said they used the probe thermometer using the Celsius temperature scale. The log does not differentiate the tool and scale used to measure the food temperatures.

According to Underwriters Laboratories Inc. Food Safety Services document, the Infrared thermometer only measured surface temperature. Therefore, when used in food applications, critical temperatures must be verified with an internal temperature measuring device.

According to Food Safety Magazine, November 2006 October/November 2006 issue; The Infrared thermometer will only measure surface temperatures and not internal temperatures. Normally, foods heat and cool from the outer surface to the interior. Therefore, a surface temperature reading may give a false indication of the interior temperature. (Author - Forensic sanitarian, Robert W. Powitz, Ph.D., MPH, RS, CFSP).

Review of the food temperature log sheets for a period of over two weeks, it was identified there was no documented food temperatures on 14 occasions.

There was no indication whether the meal being served was a hot or cold meal. Dietary staff #119 said they were to note this on the food temperature log.

Individual food temperatures found to be below the home's required food temperatures occurred 13 times during the review period.

Individual food temperatures found to be above the home's required food temperatures occurred 66 times during the review period.

Dietary staff #107 told the LTCH Inspector they had forgotten to take and document food temperatures for the morning meal on an identified date in May 2019 during the inspection period.

Dietary staff #119 told the LTCH Inspector that when the food temperatures were too high, after the food was uncovered and served, they believed it should have cooled enough to be safely served. They did not take any further temperatures or action to ensure the food was a safe temperature for the residents.

The Administrator said that staff were expected to take and document food temperatures as per the home's policy and this had not been done at all times during the review period.

The licensee failed to ensure that food was served at a temperature that was both safe and palatable to the residents. [s. 73. (1) 6.]

2. The licensee failed to ensure that meals were served course by course.

During dinner meal observation by the LTCH Inspector on two occasions in May 2019, the LTCH Inspector observed staff serving desserts to the resident prior to the entrée being completed.

On an identified date in May 2019, the RPN in charge of the dining room, was observed serving the dessert beginning with the residents who had been served their entrée last and continuing around the dining room. Many of the residents were still completing their entrée and some had their entrée dishes with partly consumed food on the plates when dessert was served.

RPN #110 was asked about the serving of the desserts and they stated they often do this to assist with the meal service.

The Administrator acknowledged that the meal service was to be course by course.

The licensee failed to ensure that the desserts were served once the entrée had been completed. [s. 73. (1) 8.]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager**

**Specifically failed to comply with the following:**

**s. 75. (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. O. Reg. 79/10, s. 75 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a Nutrition Manager to lead the nutrition care and dietary services program for the home.

During a complaint inspection regarding the quality of food being served to the residents, dietary staff #107 told the LTCH Inspector they had not had a Nutrition Manager since January 2019.

The Administrator told the LTCH Inspector that the Nutrition Manager's last date of employment with the home was February 3, 2019. Since that time there has not been a qualified Nutrition Manager employed by the home. They stated the home had advertised for this position and had hired one person with a start date of November 2, 2018. They spent two days in the home then resigned. Two other candidates were hired but did not show up at the home for their start dates.

The licensee failed to ensure there was a Nutrition Manager on staff at the home since February 3, 2019. [s. 75. (1)]

***Additional Required Actions:***

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

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Nutrition Care and Hydration Program was evaluated and updated annually in accordance with evidence - based practices or prevailing practices.

During a complaint inspection regarding food quality, menu items and food temperatures, the LTCH Inspector requested the annual program review of the home's Nutrition Care and Hydration Program.

The Administrator printed a note from the home's electronic documentation system, PointClickCare (PCC). The note was entitled "Dietitian Annual Program Review 2017". The contents of the note referenced an RD that had resigned and the new process to manage the RD responsibilities, processes for reporting to the RD and then Professional Advisory Council (PAC), missing documentation and/or assessments by the RD and the process to contact the off-site RD. The document listed some goals for 2018. There was no date, no attendees listed, no summary of changes made to the program and no dates those changes were implemented.

The Administrator stated they had no other information or documentation that would constitute an annual program review for the dietary department and there was nothing documented or found for the year 2018.

The licensee failed to ensure that the Nutrition Care and Hydration program was evaluated and updated annually. [s. 30. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that the Nutrition Care and Hydration Program is evaluated and updated annually in accordance with evidence - based practices or prevailing practices, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a back-up plan for nursing staff to address when staff, including RNs, cannot be on site.

As part of a follow-up inspection related to CO #001 from inspection #2018_580568_0017, regarding O. Reg. 79/10, s. 8 (3), wherein an RN was not always on site, the LTCH Inspector reviewed the home's staffing plan to include the back up/emergency plan for RN staffing.

The plan included calling all RNs. If there was no one available, the RN on duty was to allow a reasonable opportunity for alternative or replacement services to be provided. The plan then directed staff, if there was no RN available, to notify the DOC or the Administrator.

The Administrator said this was too vague and did not provide complete direction to staff as to what steps to take after all regular staff were called and were not available.

The back-up/emergency plan did not address the steps to take to ensure there was always an RN on site. [s. 31. (3)]

2. The licensee failed to ensure that they provided for a staffing mix that was consistent with residents' assessed care and safety needs.

As a result of a complaint regarding the home frequently not having enough PSWs to provide care, based on the assessed needs of the residents, the LTCH Inspector reviewed the "as worked" PSW schedules as provided by the home, from February 25, 2019, up to and including May 19, 2019.

The PSW staffing plan, as provided by the DOC, required two eight hour and two 12 hour day shifts, one eight hour day shift assigned for bathing, two eight hour evening shifts and two 12 hour night shifts.

The schedule review resulted in the identification that on 70 of the 74 calendar dates reviewed, for a total of 95%, the home was not staffed with PSWs as per their staffing plan. The deficiency ranged from one to four PSW shifts not covered by PSWs in a 24 hour day.

On or about March 15, 2019, the home implemented the use of a "Support Aid" to assist the PSWs with non-care related tasks. Beginning March 27, 2019, they consistently appeared on the schedule as booked to work. In some cases, they were called to work when the home was short of PSWs. The home had employed two support persons to assist, one of which they pay for the staff member's PSW training.

The substitute decision-maker (SDM) for resident #008, told the LTCH Inspector that their loved one was put to bed at 2200 hours over a specific weekend. They preferred to go to bed between 1900 and 2000 hours. They needed assistance for transfer and care. The resident told their SDM that they had to urinate in their brief as no one came when they rang the bell. On one identified occasion, the SDM stated their loved one had only their face washed before breakfast, around 0600 hours, as there was only one PSW on duty for the day shift. Resident #008 told their SDM that they were approached by one of the support aids to take them for their bath. The resident refused and told support aid #120 they would not have them bathe them and they wanted a trained PSW to provide the bath.

The SDM said they had attended a Family Council meeting and all attendees talked about the home being short staffed with PSWs. They said one person was put to bed at 0100 hours and the bells were ringing without being answered.

The minutes from this Family Council meeting noted; "Family Council is deeply concerned about the staffing shortage, and in particular, during the past weekend. Evening care for some residents was delayed by three to four hours past their regular bed time. PSWs on duty and the residents were very distressed."

Resident #009's SDM said they had witnessed, on many occasions, when the home was short staffed with PSWs. They stated they were at the home twice daily and observed when call bells went unanswered and a resident called out when their call bell was not answered. The SDM gave the home permission to put their loved one to bed right after dinner at 1800 hours, in hopes they wouldn't have to wait too long. This was not the resident's preferred bedtime. The SDM said they did this as they had witnessed where their loved one was left on their commode for almost one hour, they waited for almost an hour for their call bell to be answered and they had been left in their wheelchair for over an hour, waiting for assistance to go to bed. Resident #009 informs their SDM about times when they must wait too long for care.

During an interview with the DOC and the Administrator, they stated they were aware of the staffing shortages and shifts that were not covered. The DOC said they had revised the staffing plan to have three PSWs on days and three PSWs on evenings. A reduction of two PSWs per day to address the staffing shortage. They were unsure when they had implemented the changes. They relied on the "Indeed" website to recruit and had reached out to two local colleges who provided PSW training.

The LTCH Inspector reviewed the "as worked" PSW schedule from April 1 up to and including May 19, 2019, using the new staffing plan. On 39% of the calendar dates, the home did not have enough staffing to meet the new, reduced staffing plan.

The DOC stated when they were short staffed, for the residents who had a scheduled bath or shower that day/evening, they would be offered a bed bath. This was included in their plan of care. When asked if this had been agreed to by the resident or their SDM, they stated they had told them that was what would be offered when the home didn't have enough staff.

Documented baths were reviewed for the month of April 2019 as follows:

a) Resident #012: Preferred bath type was a tub bath. Their bath days were Monday morning and Thursday evening. On five dates of eight in April, the home did not have

enough PSWs on duty to provide the resident their preferred bath type.

b) Resident #010 preferred bath type was a tub bath. Their bath days were Wednesday morning and Sunday evening. On two of eight dates in April, the home did not have enough PSWs on duty to provide the resident their preferred bath type.

c) Resident #011preferred bath type was a tub bath. Their bath days were Tuesday morning and Saturday evening. On four of eight dates in April, the home did not have enough PSWs on duty to provide the resident their preferred bath type.

The plan of care for resident's #010, #011 and #012 had entries stating that a bed bath would be offered under extenuating circumstances. This was not the resident's preference.

The licensee failed to ensure there were enough PSWs on duty to meet the assessed care and safety needs of the residents. [s. 31. (3) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that:***
***1) a back-up plan for nursing staff to address when RNs cannot be on site and,***
***2) they provide for a staffing mix that is consistent with the residents' assessed care and safety needs, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

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

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's menu cycle was reviewed by Resident's Council.

During a complaint inspection regarding food quality, menu items and food temperatures, the LTCH Inspector interviewed a member of the Resident's Council. They stated the food was often cold, pork was a frequently offered entrée and was usually dry, when gravy was on the menu it was not always served, and many other concerns regarding meal and snack service.

The LTCH Inspector asked the member of Resident's Council when the council had last reviewed the home's menu cycle. They stated that during the two years they had been a member of Resident's Council, they had not been part of this process.

The LTCH Inspector requested the minutes from Resident's Council or a Food Committee where the menus had been presented and reviewed by the Resident's Council. The minutes for the year 2018 were reviewed and there were no documented minutes to demonstrate that the residents, during any type of committee, had reviewed the menu cycle.

The RD stated via email, that there was a Food Committee, but they had not met for over two years.

The licensee failed to ensure that the Resident's Council reviewed the home's menu cycle. [s. 71. (1) (f)]

2. The licensee failed to ensure that the home's menu cycle was reviewed and updated at least annually.

During a complaint inspection regarding food quality, menu items and food temperatures, the LTCH Inspector interviewed a member of Resident's Council. They stated the food was often cold, pork was a frequently offered entrée and was usually dry, when gravy was on the menu it wasn't always served, and many other concerns regarding meal and snack service.

Dietary staff #106 and #107 told the LTCH Inspector that the menu hadn't changed for over two years. The menu they were preparing from was dated 2017.

The RD stated via email, that since they were hired in August 2017, the menus had not been changed.

The licensee failed to ensure that the home's menu cycle was reviewed and updated annually. [s. 71. (1) (g)]

***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 the licensee must ensure that the home's menu cycle is reviewed by Resident's Council and the home's menu cycle is reviewed and updated at least annually, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 76. Cooks**

**Specifically failed to comply with the following:**

**s. 76. (1) Every licensee of a long-term care home shall ensure that there is at least one cook who works at least 35 hours per week in that position on site at the home. O. Reg. 79/10, s. 76 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was at least one cook who worked at least 35 hours per week in that position on site at the home.

During a complaint inspection regarding the quality of food being served to the residents, the LTCH Inspector reviewed the staffing schedules from January 28, 2019, up to and including May 19, 2019. The home had one qualified cook, who was scheduled to work, on average based on those schedules, 28.1 hours per week in the position of cook.

The Administrator of the home acknowledged the cook did not work the required 35 hours per week.

The licensee failed to ensure there was a cook on site at least 35 hours each week. [s. 76. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that there is at least one cook who works at least 35 hours per week in that position on site at the home, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications**

**Specifically failed to comply with the following:**

**s. 78 (5) Subsection (1) does not apply with respect to,**
**(a) students hired on a seasonal or part-time basis, who have successfully completed a food handler training program;**
**(b) persons who meet the qualifications in subsection 75 (2) or 76 (2) or who are exempt from meeting those qualifications as they meet the requirements under subsection 75 (2.1) or 76 (4); or**
**(c) persons who have a post-secondary diploma in food and nutrition management or a post-secondary degree in food and nutrition.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that students hired on a part-time basis, as a food service worker, had successfully completed a food handler training program.

During a complaint inspection regarding the quality of food being served to the residents, the LTCH Inspector reviewed employee files of three students currently employed on a part-time basis in the dietary department. Dietary staff #115, #116 and #117's duties included, but were not limited to, setting up of the beverage cart, washing dishes, serving beverages, assisting with meal service, storing and dating left overs, setting up the evening nourishment cart and cleaning the dining room and kitchen floors.

None of the students had completed, nor were enrolled in a food handler training program. They provided evening dietary aide services in the home, seven days per week.

The Administrator acknowledged the three students had not completed a food handler training program.

The licensee failed to ensure that the student dietary aides had successfully completed a food handler training program. [s. 78. (5) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that students hired on a part-time basis, as a food service worker, have successfully completed a food handler training program prior to working in the dietary department, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that no person performed their responsibilities before receiving training.

During a follow up inspection to CO #001 from inspection #2018_580568_0017, regarding s. 8 (3) related to ensuring there were always one RN in the home, the LTCH Inspector reviewed the RN schedules from January 28 to May 14, 2019.

The home's policy "Orientation for Registered Staff:, with a revised date of August 2018, directed that the purpose of the policy was to ensure competent staff to be well equipped to meet the care needs of the residents. It listed 15 areas to be trained on and included a three page orientation checklist.

On an identified date in February 2019, it was noted that RN #118 was at the home for their first day of employment. During that day, they completed on-line training.

The training did not include the following:

1) All Acts, regulations, policies of the Ministry and similar document, including policies of the licensee, that were relevant to the person's responsibilities,
2) Any other areas provided for in the regulations,
3) Mental health issues, including caring for persons with dementia,
4) Behaviour management,
5) Palliative care,
6) Falls prevention and management,
7) Skin and wound care,
8) Continence and bowel care,
9) Pain management, including pain recognition of specific and non-specific signs of pain,
10) Safe and correct use of equipment, and
11) Cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

The following day RN #118 was assigned to work as the RN on duty in the home.

The licensee failed to ensure that RN #118 had completed the required training prior to performing their responsibilities. [s. 76. (2)]

**Issued on this 24th day of June, 2019**

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

**Original report signed by the inspector.**

**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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | HEATHER PRESTON (640) |
| **Inspection No. / No de l'inspection :** | 2019_787640_0017 |
| **Log No. / No de registre :** | 030326-18, 032624-18, 000994-19, 010063-19 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jun 19, 2019 |
| **Licensee / Titulaire de permis :** | Golden Dawn Senior Citizen Home<br>80 Main Street, Lion's Head, ON, N0H-1W0 |
| **LTC Home / Foyer de SLD :** | Golden Dawn Nursing Home<br>80 Main Street, Lion's Head, ON, N0H-1W0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Barbara Stirling |

To Golden Dawn Senior Citizen Home, 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)

**Linked to Existing Order / Lien vers ordre existant:** 2018_580568_0017, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must comply with the LTCHA, 2007, s. 8 (3).

Specifically, the licensee must:

1) Track and record the recruitment strategies that have been implemented and the date of each strategy, the number of interviews with Registered Nurses (RN), the number and dates of employment offers and acceptances of RNs and number of RNs that have resigned their position and the dates of the resignations and,
2) ensure there is an RN, who is a member of the regular nursing staff, on duty and present in the home at all times.

**Grounds / Motifs :**

1. The licensee failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2018_580568_00017 regarding S. O. 2007, s. 8 (3), with a CDD of January 11, 2019, wherein the home did not have an RN on duty and present in the home at all times.

The LTCH Inspector reviewed the RN schedules from January 28, 2019 up to

and including May 14, 2019. There were 12 occasions where an RN who was a regular member of the nursing staff, was not present in the home. Three occasions were related to severe weather. On one occasion there was an RN in the building, however RN #118 had been hired the previous day and had not completed mandatory training or any orientation to the home and the duties of the RN.

RPNs #100 and #105 said they had been left in charge of the building without an RN on site on a few occasions. RPN #105 was hired in March of 2018 and said they used to be scheduled for night shift without an RN on site. RPN #100 said they worked a night shift approximately two weeks ago without an RN on site.

The DOC reviewed the schedule and stated the dates identified did not have an RN on site. The Administrator was not aware there had been an issue with the RN staffing.

The Administrator provided documentation about RN job postings to include Indeed and the home's website. They stated they struggle to compete with other home's pay rates and the location of the home is difficult for many potential candidates. They had four RNs accept employment. Two remain, one attended the home for two shifts then left and another did not show up for their orientation.

The DOC acknowledged the home had not ensured there was always an RN, who was a regular member of the nursing staff, on site at all times.

The severity of this issue was determined to be level 3, actual risk. The scope of the issue was determined to be level 1, isolated, as five percent of the required shifts during the review period, did not have an RN on duty at the home. The compliance history was determined to be level 4 as there were three previous compliance orders related to the same area as follows:

- Follow up inspection #2018_580568_0017 with CO #001 issued November 11, 2018, with a compliance due date of January 11, 2019
- Follow up inspection #2017_580568_0021 with CO #001 issued October 31, 2017, with a compliance due date of December 31, 2017

- CO #001 issued November 1, 2016, with a compliance due date of February 28, 2017 (2016_325568_0020)

(640)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 06, 2020

**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. 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

**Order / Ordre :**

The licensee must comply with O. Reg. 79/10, s. 72 (3).

Specifically, the licensee must:
1) Take food temperatures as directed by their local Public Health during cool down of fully cooked and hot held foods,
2) Follow the licensee's policy related to leftovers and the direction given by the local Public Health Inspector and,
3) Train all dietary staff on the proper management of leftover food items.

**Grounds / Motifs :**

1. The licensee failed to ensure that all foods in the food production system were stored using methods to prevent adulteration, contamination and food borne illness.

During a complaint inspection regarding food quality, the LTCH Inspector interviewed a member of Resident's Council. During that interview, they said that the home kept the leftover food from the served meals and served them at a later date.

The LTCH Inspector observed a complete dinner service during their inspection. They observed a dietary staff member deciding which leftover food items in the steam table had enough to save and re-use. The dietary staff member stated they re-purposed the leftovers from the steam table when there were enough to do so. They put the item in a storage container, left it on the counter in the kitchen for various periods of time, then labeled it and placed it in the freezer.

Dietary staff #103 said they do not take any temperatures of the food during the cool down period. They just knew how long the item should sit before going into the freezer.

The licensee's policy "Use of Leftover Foods", policy #B.9 with a revised date of July 2014, directed staff that following meal service, any foods that had been served to residents were to be discarded. It directed that food that was leftover was only considered suitable to be retained and used again for residents if the product had been held at a safe temperature, the holding time had not exceeded acceptable limits and the quality had not deteriorated.

The LTCH Inspector interviewed the home's local public health inspector who stated that any food that had been in the steam table was not to be saved and re-used by any means.

During observation of the freezer, the LTCH Inspector observed more than 40 containers of frozen food items. All labeled, some without a date and a couple dated from March 26, 2019. The containers were previously used margarine tubs, ice cream and yogurt containers and various others. On the freezer door, dietary staff #107 pointed out a list the staff kept when they placed leftovers in the freezer. The list contained approximately 68 items categorized under beef, liver, pasta, pork, chicken/turkey, fish, lamb, vegetables, soups and other food items. None of the named items on the list had a date associated with them.

The licensee failed to ensure that all food items were stored to prevent adulteration, contamination and food borne illness.

The severity of the issue was determined to be level 3, actual risk. The scope of the issue was determined to be level 3, widespread. The compliance history was determined to be level 2, with previous non-compliance in other areas of the LTCHA.
(640)

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

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Aug 30, 2019

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

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**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

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

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

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10, s. 73 (1).

Specifically, the licensee must:

1) Train all dietary staff on the correct method, correct equipment and required times for taking food temperatures,
2) Follow the licensee's policy related to the taking and recording of food temperatures and,
3) Follow direction regarding the taking of food temperatures given by the local Public Health Inspector including best practices for type and use of food temperature thermometers.

**Grounds / Motifs :**

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

During a complaint inspection regarding food quality, menu items and food temperatures, the LTCH Inspector interviewed a member of the Resident's Council. They stated the food was often cold and had poor flavour. They said they no longer had the hot meal at breakfast as it was "always" cold. They said that the vegetables were nearly always cold. You could not even melt butter on them they were so cold. They very seldom had flavour.

Resident's Council discussed food temperatures and poor food quality on September 10 and November 7, 2018 and January 14, 2019.

Family Council discussed continuing concern about the quality of meals for the residents on December 19, 2018.

The home's policy "Food Service Temperatures", policy #D.2 with a revised date of July 2014, directed staff to take food temperatures in the centre of the thickest part of the food, when cooking, chilling, hot-holding or reheating all food products. All designated dietary staff members record all hot food temperatures on completion of the cooking process, on the Food Temperatures Recording chart and initial the entries. A Food Temperature Recording Chart was also completed for all hot menu items and for cold foods in the serveries prior to meal service. Hot foods must be held at a minimum temperature of 60 degrees C (140

F) and may be held a maximum of two hours.

During the inspection, the LTCH Inspector observed the supper meal from beginning to end. They tasted each of the items and found the flavour was basic but not offensive to the Inspector. The mixed vegetables were cool.

The LTCH Inspector observed dietary staff #103 taking food temperatures of all foods being held in the steam table, using an Infrared thermometer. When asked, they stated they were informed to use this tool by their previous manager as it was smarter than the other type.

The cook documented entrée #1 to be 179.2 degrees Fahrenheit (F) using the infrared thermometer. The LTCH Inspector's internal probe thermometer read 93.7 Celsius (C) which converted to 200.66 degrees F temperature. The mixed vegetables, using the infrared thermometer was documented by the cook to be 156.7 degrees F. The LTCH Inspector's internal temperature probe was 87.8 C which converted to 190.4 degrees F both outside the home's acceptable high temperature range of 170 degrees F.

The served food temperatures were taken, by the LTCH Inspector using the internal temperature probe, from a resident's meal. Entrée #1 was 87 degrees C and the mixed vegetables were 50.8 degrees C. This was a loss of 6.7 degrees C for the entrée and 37 degrees Celsius for the mixed vegetables from temperatures taken at the steam table to when the meal was served to the resident.

Dietary staff #103 and #107 told the LTCH Inspector they used the infrared thermometer to check the food temperatures using the Fahrenheit temperature scale. Dietary staff #119 said they used the probe thermometer using the Celsius temperature scale. The log does not differentiate the tool and scale used to measure the food temperatures.

According to Underwriters Laboratories Inc. Food Safety Services document, the Infrared thermometer only measured surface temperature. Therefore, when used in food applications, critical temperatures must be verified with an internal temperature measuring device.

According to Food Safety Magazine, November 2006 October/November 2006 issue; The Infrared thermometer will only measure surface temperatures and not internal temperatures. Normally, foods heat and cool from the outer surface to the interior. Therefore, a surface temperature reading may give a false indication of the interior temperature. (Author - Forensic sanitarian, Robert W. Powitz, Ph.D., MPH, RS, CFSP).

Review of the food temperature log sheets for a period of over two weeks, it was identified there was no documented food temperatures on 14 occasions.

There was no indication whether the meal being served was a hot or cold meal. Dietary staff #119 said they were to note this on the food temperature log.

Individual food temperatures found to be below the home's required food temperatures occurred 13 times during the review period.

Individual food temperatures found to be above the home's required food temperatures occurred 66 times during the review period.

Dietary staff #107 told the LTCH Inspector they had forgotten to take and document food temperatures for the morning meal on an identified date in May 2019 during the inspection period.

Dietary staff #119 told the LTCH Inspector that when the food temperatures were too high, after the food was uncovered and served, they believed it should have cooled enough to be safely served. They did not take any further temperatures or action to ensure the food was a safe temperature for the residents.

The Administrator said that staff were expected to take and document food temperatures as per the home's policy and this had not been done at all times during the review period.

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

The severity of this issue was determined to be level 3, actual risk. The scope of the issue was determined to be level 3, widespread. The compliance history was determined to be level 2, previous non-compliance to another section of the LTCHA.

(640)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Aug 30, 2019

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

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**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 75. (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. O. Reg. 79/10, s. 75 (1).

**Order / Ordre :**

The licensee must comply with O. Reg. 79/10, s. 75 (1) of the LTCHA.

Specifically, the licensee must ensure that there is a nutrition manager for the home to lead the nutrition care and dietary services.

**Grounds / Motifs :**

1. The licensee failed to ensure that there was a Nutrition Manager for the home to lead the nutrition care and dietary services program for the home.

During a complaint inspection regarding the quality of food being served to the residents, dietary staff #107 told the LTCH Inspector they had not had a Nutrition Manager since January 2019.

The Administrator told the LTCH Inspector that the Nutrition Manager's last date of employment with the home was February 3, 2019. Since that time there has not been a qualified Nutrition Manager employed by the home. They stated the home had advertised for this position and had hired one person with a start date of November 2, 2018. They spent two days in the home then resigned. Two other candidates were hired but did not show up at the home for their start dates.

The licensee failed to ensure there was a nutrition manager on staff at the home since February 9, 2019.

The severity of this issue was determined to be level 2, minimal risk. The scope of the issue was determined to be level 3, widespread as the home has not had a nutrition manager since February 3, 2019. The compliance history of this issue was determined to be level 2, previous non-compliance to a different section of the LTCHA.
(640)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 09, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

**Issued on this 19th day of June, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Heather Preston

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office