Ontario

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

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

Order(s) of the Inspector

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public
Name of Inspector (ID#):	ASHA SEHGAL (159), DEBORA SAVILLE (192), GILLIAN HUNTER (130), LESA WULFF (173)
Log #:	H-001332-11, H001216-11, H-001449-11
Inspection Report #:	2011_071159_0012
Type of Inspection:	Resident Quality Inspection
Date of Inspection:	Jul 7, 11, 12, 13, 14, 15, 18, 20, 21, 22, 25, 26, 28, 29, Aug 2, 4, 5, 8, 9, 10, 11, 12, 17, 18, 19, 27, 29, 30, 31, Sep 2, 6, 7, Oct 3, 2011
Licensee:	KING NURSING HOME LIMITED 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home:	KING NURSING HOME 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator:	JANICE KING

NOTE: This Inspection Report has been revised to reflect a decision of the Director on a review of an Inspector's Order(s). This revised report replaces the original report issued for this Inspection.

To King Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order:
The licensee shall immediately ensure that the plans of care for the following residents are reviewed and revised to provide clear direction to staff as identified below:

a) A specified resident related to weight changes and activities of daily living
b) A specified resident related to nutritional needs and safety risks
c) A specified resident related to oral care and continence
d) A specified resident related to continence, pain and mobility
e) A specified resident related to transfers and oral care.

Grounds:

1. The plan of care does not provide clear direction for the resident care needs. The plan of care for a specified resident indicates that the resident is independent for oral care with set up. Interview with staff and a record review indicates that the resident requires total assistance for oral care and will not complete the task independently. The resident has no identified toileting routine included in the plan of care. Staff interviewed gave conflicting reports related to when the resident should be toileted.
2. The plan of care for a specified resident related to oral care indicates that staff are to provide oral care-there is no direction related to the frequency care is to be provided or how it is to be provided. The plan of care for this resident does not provide clear direction related to transfers as it identifies that two staff are required for the sara lift as the resident is unable to participate although it also indicates that the resident uses a Maxi-lift for transfers at all times.
3. The plan of care for a specified resident under Mobility indicates that all physiotherapy is on hold, although during interview it was identified that the resident is currently receiving active and passive range of motion. During interview it was identified that the resident requires positioning to promote comfort. The resident indicated in interview that there is discomfort that interrupts sleep. Positioning for comfort is not addressed on the plan of care. Under bowel and bladder continence the plan of care indicates that the specified resident is to be toileted before meals, after meals, at bed time and as necessary. Staff interviewed indicated that the resident has an incontinence product changed in the morning after meals and with bedtime care. The plan of care does not reflect care the resident is receiving.
4. The plan of care does not give clear direction to staff providing care. The plan of care for a specified resident provides conflicting information related to the resident's swallowing and diet order. The resident requires one bed rail raised when in bed and a crash mat on the floor, however, as a result of a fall, two bed rails/restraints were ordered for this resident while in bed. Directions for staff were not updated in the plan of care to reflect this change.
5. The plan of care for a specified resident does not identify clear goals, objectives and specific strategies for weight loss. The plan of care 2011 states "to achieve a personal weight loss goal over the next three months". Review of the progress notes documented by the Registered Dietitian states

that the resident's personal weight loss goals are unsafe. No direction is provided for dietary interventions for safe weight loss.

This order must be complied with by:	October 28, 2011

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

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order:
A) The licensee shall immediately ensure that the following residents are reassessed and the plan of care reviewed and revised as the resident's care needs have changed and/or the care set out in the plan is ineffective:
a) An identified resident related to weight loss and responsive behaviours
b) An identified resident related to ongoing falls and responsive behaviours
c) An identified resident related to mood status
d) An identified resident related to falls

B) The licensee shall prepare, submit and implement a plan ensuring that all residents of the home are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. The plan is to be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **Sept 2, 2011.**

Grounds:
Previously issued August 17, 2010 under the Long Term Care Program Manual as B 1.6, B2.4 and O.Reg. 79/10 s. 26(3)13

1. An identified resident sustained 10 falls over a nine month period. The plan of care related to falls was not revised nor were strategies developed when assessments identified risks, when residents' outcome scales had changed, and when interventions were found to be ineffective. (130)

2. The plan of care for an identified resident was not revised despite 7 recorded falls over an eight month period in 2011. The resident exhibits verbal and physical aggression daily and based on assessment has experienced a change in their mood status. The plan of care for the resident was not reviewed and revised when interventions were ineffective and the resident's assessed needs changed. The resident had an MDS assessment completed in 2011 that indicated there had been a change in her mood status. Interventions were not initiated for the assessed change in mood status. (192)

3. An identified resident exhibits persistent anger and verbal aggression daily. The MDS assessment completed in 2011 indicates that the resident's behaviours had deteriorated. The plan of care was not

updated to reflect these identified changes in behaviour when it was reviewed the next day after the MDS assessment was completed. Specific interventions related to the identified behaviours are lacking. An identified resident had a significant weight loss over three months. The plan of care for the resident was not reviewed or revised in relation to the weight change. There was no evidence of reassessment completed by Registered Dietitian or initiation of appropriate interventions. (159)

4. An identified resident sustained four falls since a specified time in 2010. The plan of care for the resident was not reviewed and interventions were not revised when the plan was found to be ineffective in reducing the number of falls. (130)

This order must be complied with by:	Sep 02, 2011

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

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are Integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order:

1. The licensee shall immediately ensure that staff and others involved in the different aspects of care of the residents listed below collaborate with each other in the assessment of these residents so that their assessments are integrated and are consistent with and compliment each other.

a) An identified resident related to nutrition and hydration
b) An identified resident related to falls
c) An identified resident related to responsive behaviours
d) An identified resident related to falls

2. The licensee shall develop a process that ensures that staff and others involved in different aspects of care for all residents of the home, consistently collaborate with each other in their assessments.

Grounds:

1. For an identified resident, there are 10 recorded falls for a nine month period. Post falls assessments do not always contain accurate information related to the resident's fall history and information related to gait analysis is not consistent and/or complete.
The plans of care for two identified residents are not based on an interdisciplinary assessment with respect to risk of falls. There is no evidence to support that disciplines other than nursing are involved in the assessment and development of a plan in relation to falls prevention.
Post fall assessments are not always complete and do not always contain accurate information, which is resulted in an inaccurate risk level. For example, the post fall risk assessment completed in 2010 indicates

that a resident is at moderate risk for falls, the post fall risk assessment completed seven days later indicates the resident is at low risk for falls. The post falls risk assessment completed the next month still identifies the resident is at low risk for falls despite four recorded falls in less than two months. s.6(4)(a)
The current Falls Prevention and Management Program does not provide evidence that departments other than nursing are involved in the assessment and review of residents in relation to falls. The revised Falls Prevention and Management Program involves other disciplines, however, this has not been fully implemented to date. (130)

2. There has been no collaboration between disciplines in the plan of care for an identified resident in relation to pain.
The Observation Record completed by the Personal Support Workers indicate that the resident was in pain 24/31 days in one month in 2011 and 14/30 the subsequent month. Weekly assessments indicate that there is no breakthrough medication for pain despite documentation by the Personal Support Workers that the resident was experiencing pain almost daily. Physiotherapy (PT) interventions for pain management identified in the plan of care are currently on hold.
There is no current PT assessment on the medical record that addresses the resident's needs or the presence of pain. Interview with the resident indicates that their sleep is frequently interrupted by pain. Personal Support Workers frequently document on the Observation Record that there have been changes in the resident's sleep patterns. This has not been addressed during assessment by the interdisciplinary team. (192)

3. Conflicting information was noted between the RAPs summary completed by different staff. Dehydration and fluid maintenance triggered RAP completed in 2011 by Registered Nursing staff stated that an identified resident was refusing to drink and their intake was below their daily required amount of fluids, that the resident was at risk for dehydration, and that the resident would be encouraged to drink popsicles and jello would be offered. The nutritional status triggered RAP, completed by Registered Dietitian five days later, stated fluid intake was above the recommended amount of 1500ml/day. Staff did not collaborate with each other in the assessment and development of the plan of care for the resident . (159)

This order must be complied with by:	Sep 12, 2011

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

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

Order:

The licensee shall immediately ensure that care set out in the plan of care is provided to the following residents as specified in the plan of care:
a) An identified resident is to be attended by 1:1 staff at all times
b) An identified resident will be provided 1:1 visits and encouraged to participate in group activity and will be provided checks every 15 minutes related to their safety as required.
c) An identified resident will be provided 1:1 visits and encouraged to participate in group activity

d) An identified resident will be provided with oral care twice daily
e) An identified resident will be provided continence care as outlined in their plan of care - before and after meals, at bedtime and as necessary in the manner of their choosing.

Grounds:
Previously issued Aug 17, 2010 with a VPC

1. An identified resident was observed on two occasions to have food debris on and between their teeth and on one occasion with halitosis. Staff interviewed indicated that the resident can be resistive at times and mouth care was not completed. The plan of care for oral/mouth care indicates that the resident requires one staff to complete entire task twice a day and whenever required. (173)

2. An identified resident was unable to initiate independent social activity. The resident was not provided recreation and social activities as per the plan of care. Resident participation in the recreational programming was not observed nor documented on the home's participation report for three months in 2011. Recreational staff confirmed the information was not recorded as 1:1 recreational programs were not delivered to resident. (159)

3. A specific resident was identified to be at risk of harm requiring checks every 15 minutes. The resident was observed on July 21 and 23, 2011 for periods greater than two hours on each day and was not checked by staff for periods greater than 30 minutes on multiple occasions. Interview with staff and documentation in the medical record indicates that checks were completed hourly. Staff were unaware of any risk of harm to the resident. The plan of care for an identified resident states that the resident will participate in 1:1 activities 3 times per week. Staff 1:1 visits or encouragement to participate in any of the daily activities did not occur at the time of the inspection. Recreational staff confirmed the 1:1 recreational programs were not delivered to resident. (159) .

4. Staff left an identified resident unattended for an unknown period of time in 2011. The resident was aggressive towards a co –resident during this time. The plan of care clearly states that the staff are to have another PSW relieve the staff at all times. The plan of care states that this resident is not to be left alone. (173)

5. Continence care for an identified resident was not performed as per the plan of care. The resident was incontinent and had several open areas on their skin, increasing their risk for further skin breakdown. Staff, during interview confirmed that the toileting schedule for the resident is not followed as outlined in the plan of care.
The plan of care indicates that an identified resident is to receive a tub bath twice weekly. The resident has received bed baths, not tub baths for several months in 2011 and the baths were not consistently given twice weekly. (192)

This order must be complied with by:	Aug 30, 2011

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

Pursuant to:
O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the

licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order:

The licensee shall prepare, submit and implement a plan to ensure that the following required procedures, strategies or systems are complied with:

a) Oral Care
b) Continence/Incontinence Guidelines for care
c) Mechanical Lifts/Lifting Policy
d) Pain Management
e) Abuse and neglect of a resident

The plan shall be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by October 31, 2011.

Grounds:

1. Policy and procedure VII-E-10.0 called Abuse and Neglect of a resident-actual or suspected, states that: "All staff and volunteers will receive in-service education on the topic of abuse and neglect and the reporting of abuse and neglect."

The home has provided only one in-service education session related to abuse, neglect and whistle-blowing protection in the past year. There were only 22 staff present for this in-service education. No other attempts to repeat the education have been made and ensure that all staff have received the required training.

Pain and Symptom Assessment and Management Protocol Policy # VII-G-70.00 dated July 2011 requires that registered staff completed and document a pain assessment on initiation of a pain medication, or when there is a change in condition with pain onset, distress related to behaviours or facial grimacing.

A specified resident is on an analgesic for pain. The resident is currently experiencing pain from a new source – no assessment has been completed related to this new source of pain.

A specified resident is on analgesic related to pain. The pain continues and the resident states that it often interrupts their sleep. No further assessment has been conducted related to this pain.

The policy indicates that a 24 hour Pain and Symptom Monitoring Tool is to be used when a scheduled pain medication does not relieve the pain, when pain remains regardless of interventions, pain medication is changed or an empiric trial of analgesics is started. Interview with the Director of Care indicates that the 24 hour Pain and Symptom monitoring tool is not in use in the home.

2. The home's policy on the use of Mechanical Lifts/Lifting Policy number J-1 is not complied with. The plan of care for a specified resident indicates that two staff are to interlock arms with the resident and provide support during transfer. The resident participates sometimes with the transfer. The home's policy

indicates that "the preferred method of lifting will be conducted with the use of mechanical lifting devices, including one-person, two-person, and three person lifts (not transfer)". Staff is not to attempt to lift any weight over 40 lbs and adherence to proper body mechanics is a must. The specified resident's weight is significantly higher than the 40 pounds indicated in the policy. Staff was observed lifting the specified resident from the floor to the bed.

3. The licensee did not ensure that their Policy for Oral care was complied with by care staff. Policy #B 35 called Personal Hygiene – Oral Care: Policy and Guidelines indicates that staff are to provide residents the opportunity to perform oral care twice a day. If the resident is not able to perform this care themselves then they will be assisted by care staff. Oral care was inspected for a specified resident for two days of the inspection. The resident did not receive oral care on either day. Staff confirmed the lack of care during interview on July 23, 2011 stating the resident was too sleepy to perform the care. The resident was observed to have food debris on the teeth on several occasions and was noted to have mouth odour on one occasion.

4. The policy "Promoting Continence" Policy #VII-E010.00 requires that Registered staff will complete all documentation regarding the resident's level of bladder/bowel continence or incontinence and planned interventions in the appropriate areas of the resident's record such as progress notes, quarterly summaries and annual reviews, medication records, flow sheets and care plan.

The plan of care related to incontinence of bowl and bladder for a specified resident does not reflect the assessed level of continence or incontinence of the resident or the planned interventions required for the resident. Staff were not clear on the continence care needs for the resident or when care should be provided.

During interviews staff indicated that residents are checked and changed upon waking and after meals. One Personal Support Worker indicated that residents are checked, changed and toileted every 2-3 hours. Observation of a specified resident on July 28, 2011 – the resident was not checked, changed or toileted before lunch and for a period of 2 hours and 45 minutes during observation.(1100 – 1345). Evening staff interviewed indicated those residents were checked, changed or toileted before supper and at bedtime.

This order must be complied with by:	November 15, 2011

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

Pursuant to:
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:

A. The licensee shall immediately ensure the following:
a) pureed food prepared for residents requiring altered texture will be prepared in a manner that preserves taste, nutritive value, appearance and food quality.

b) standardized recipes are consistently followed.
c) desserts such as ice cream are maintained at an appropriate temperature, before being served and that vegetables are cooked to preserve quality.
d) that food served to residents on the third floor is of equal quality to that served in other areas of the home and is not held for an extended period in the steam cart before being served.

B. The licensee shall prepare, submit and implement a plan to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality. The plan shall be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **Sept 2, 2011.**

Grounds:
Previously issued August 17, 2010, related to following of recipes, with a VPC

1. During meal observation on July 7, 2011, residents on the third floor received a pureed alternative that compromised the appearance, nutritive value and taste as well as increasing the risk for choking for some residents. The Salmon Sandwich and Garden Salad were very liquid and ran into each other on the plate. (192)

2. July 14, 2011, at approximately 1325 plated desserts (pureed orange slices, yogurt and ice cream) were noted on the sink counter. The ice cream was melted and almost liquefied. Residents were served melted ice cream. The quality, appearance and taste of these items were compromised.
The hot food served to residents who eat on the third floor unit was held on the hot cart for an extended period of time (over one hour) before the service, which had compromised the quality, appearance, taste and nutritive value. (159)

3. Not all foods and fluids were prepared, stored and served using methods which preserves taste, nutritive value, appearance and food quality. July 14, 2011, pureed quiche served for lunch was starchy and sticky, had excessive starch content and lacked protein. July 20, 2011 vegetable (broccoli) served was over cooked and mushy.
Standardized recipes at the lunch meal July 21, 2011 were not consistently followed. Ingredients were not measured or weighed as listed on the recipes (i.e. cucumber and onion salad, and pureed french fries), resulting in reduced nutritive value, taste and appearance. Recipes for cucumber salad called for 1 1/8 cup of vinegar, cook used 2 teaspoons. For pureed french fries, milk and fries were not measured for the number of servings required.
Residents on the third floor did not receive the same level of food quality and palatability as residents on the first and second floor. Hot foods were panned and set up on the steam cart before 1120 hours to be served to the residents on the third floor at 1230 hours. The hot food held for an extended period (over an hour) in the steam cart, not only reduces the nutritive value, taste and appearance but also compromises quality. (159)

This order must be complied with by:	Sep 02, 2011

Order #:	007	**Order Type:**	Compliance Order, Section 153 (1)(a)]

Pursuant to:
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:

The licensee shall immediately ensure that food and fluids are being served to all residents at a temperature that is both safe and palatable to the residents. Food temperatures for all items are to be taken and recorded before being served. Food and fluid temperatures that are not within the expected range are to be immediately reported to the Food Services Supervisor or designate and immediate action taken to ensure food served is at the appropriate temperature.

Grounds:

1. Food and fluids were not served at a temperature that was both safe and palatable to the residents. July 20, 2011 at the observed lunch third floor dining room at 12:30 pm, food temperatures were tested in the presence of Food Service Manager and a dietary aide. The temperatures recorded were found to be: cold turkey sandwiches 20 degree Celsius but should have been at 5 degrees Celsius, omelettes 40 degree Celsius, should have been at 60 degrees Celsius and corn salad 20 degree Celsius should have been served at 5 degrees Celsius. Hot and cold foods not served at safe temperatures compromise palatability, reduces food intake, but also increases the risk for food contamination. (159)

2. Review of Residents Council meeting minutes, March, April, and May 2011, indicates residents have voiced concerns about the food temperatures, and the food quality (meat tough). It is noted that the concerns about hot food not served at acceptable and safe temperatures were repeatedly voiced by the residents at the Residents' Council meetings. (159)

This order must be complied with by:	Aug 30, 2011

Order #:	008	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
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:

A. The licensee shall immediately ensure that:
i) The call bell in an identified resident's room is accessible and easily activated by the resident
ii) All call bells are positioned to promote access by residents.
iii) The call bells in tub and shower rooms are easily accessible by staff and residents
iv) Call bells in five identified rooms are easily seen, accessible and activated

Grounds:

1. July 8, 2011 - Call bell in an identified room is laying on the floor at the head of the bed. It is noted to be very difficult to activate.
2. July 8, 2011 at 1115 - Call bell in tub room is difficult to access if a staff member was working with a resident alone as it is located on the far side of the tub, located near the ceiling.
3. July 12 - First Floor tub room - call bell over the tub was tested, cord broke. Call bell beside the toilet in the same tub room only works when pulled side ways, using a lot of force.
4. July 8, 2011 - Call bell in the bathroom of an identified room was pulled by the end of the cord and would not activate the call system, when pulled close to the wall, the cord pulled away from the call bell.
5. July 12, 2011 - the call bell in the bathroom of an identified room - when pulled the cord stretches and requires a great deal of effort to activate the call bell.
6. July 12, 2011 the bathroom call bell for an identified room is looped through eye hooks which make it very difficult to activate.
7. July 8, 2011 the call bell in an identified room is difficult to activate without force. (173)

This order must be complied with by:	Sep 02, 2011

Order #:	009	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order:

1. The licensee shall immediately reassess the designated transfer/lifting techniques used for an identified resident to ensure that the resident is transferred/lifted safely and according to the homes policy related to Lifts and Transfers.

2. The licensee shall communicate the assessed needs of an identified resident to all staff responsible for the resident's care to ensure that the resident is consistently transferred/lifted in a safe manner.

Grounds:

1. Staff does not use safe transferring and positioning techniques when assisting residents.
During the inspection an identified resident was observed rolling off their bed onto the floor mat. Three Personal Support Workers were observed attempting to lift the resident from the floor. The PSW's did not call for the registered staff member to assess the resident prior to attempting to lift the resident from the floor. No effort was made to bring a lift to the room to complete the transfer. Three unsuccessful attempts were made to transfer the resident without using a lift. The registered staff member arrived at this time to complete an assessment. The plan of care indicates that the resident should be transferred using 2 staff to interlock arms with the resident and support them during transfer. (192)

This order must be complied with by:	Aug 30, 2011

Order #:	010	**Order Type:**	Compliance Order, Section 153 (1)(a)

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

Order:

The licensee shall immediately ensure that post fall assessments using a clinically appropriate assessment instrument are completed on three identified residents and any other resident sustaining a fall, where the condition or circumstances of the resident require a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls.

Grounds:

1. The licensee has not ensured that when a resident has fallen the resident is assessed and where the condition of the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument.
An identified resident sustained falls in 2010 and 2011 at which time no falls assessments were conducted. A clinically appropriate assessment tool was not used to assess the resident post falls (5 dates in 2010 and 2011). (130)

2. An identified resident sustained one fall in 2010 and two falls in 2011 at which time; no post fall assessment was conducted. The resident had 7 other falls over the same 9 month period. Post fall assessments do not always contain accurate information related to the resident's fall history and information related to gait analysis was not consistent and/or complete. (130) 3. An identified resident sustained 3 falls over approximately a one month period in 2010, however a post fall assessment was not completed after these falls occurred or after a second fall occurred on the same day. The Director of Care confirmed through interview that a clinically appropriate falls assessment instrument is not currently available for staff use. (130)

This order must be complied with by:	Sep 02, 2011

Order #:	011	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order:

The licensee shall ensure that:

a) training is provided to staff on the use of the clinically appropriate pain assessment/instrument, determined as appropriate for use in the home, and
b) that a monitoring program is put in place to ensure the clinically appropriate pain assessment instrument is used by staff in all cases where a resident's pain is not relieved by initial interventions.

Grounds:

1. An identified resident had a fall in 2011 and sustained an injury. The analgesic given post fall was not effective in relieving the pain. The resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. The resident received analgesic, the pain was not relieved – no pain assessment was conducted using a clinically appropriate assessment tool. Discussion with the Registered Practical Nurse confirms that no pain assessment was conducted related to the pain sustained by the resident. Discussion with the Director of Care confirms that there is no clinically appropriate assessment instrument in use at the home at this time. (192)

This order must be complied with by:	November 30, 2011

Order #:	012	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order:

The licensee shall immediately assess two identified residents' behaviours, and all other residents with responsive behaviours, identify triggers, develop effective interventions and document the residents responses to interventions.

Grounds:
Previously issued with a VPC August 17, 2010

1. The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary assessment of the resident that includes identified responsive behaviours, potential behavioural triggers, actions taken to respond to the needs of the resident and the resident's response to the interventions.
A review of the Resident Assessment (RAP) completed in 2011 also indicates that the resident exhibits behaviours. Documentation in the progress notes does not indicate the presence of any such behaviour since May 2011. The plan of care indicates that the resident resists care - it is not specific as to the types of care being resisted or when the behaviour occurs. There are no other behaviours noted in the plan of care and there have been no updates or changes to the plan of care based on reassessment or evaluation of the responsive behaviours since the decrease noted by staff in the progress notes. (192)

2. The licensee has failed to identify the behavioural triggers, develop effective interventions and document the residents response to interventions related to responsive behaviours as follows:
Assessments and the plan of care completed for an identified resident do not include triggers for responsive verbal and physically aggressive behaviours. The resident displays unpredictable behaviours that have resulted in several altercations and harm to co-residents. Staff were not able to verbalize triggers to these behaviours or identify any interventions to prevent occurrences.
The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary assessment of the resident. There is no documentation of potential triggers included in the plan of care related to the identified behaviours indicated in the home's documentation. A review of the documentation in the Observation Record indicates that the resident also exhibits some of the behaviours daily. There are no progress notes indicating that the resident has exhibited any of these behaviours since May 2011. Inspectors on site for 16 days of the review did not observe the resident displaying any of the identified behaviours. The quarterly review completed in 2011 indicates that the resident has sustained a mood change since the last quarter, however, there are no details related to this change and no change in the plan of care as a result. The staff indicate that the interventions in the plan of care were effective.
Discussion with the Director of Care confirms that assessments are not consistently completed for residents with behaviours. (192) (173).

This order must be complied with by:	Sep 12, 2011

Order #:	013	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order:

The licensee shall immediately complete interdisciplinary assessments and care planning for two identified residents and all other residents with documented responsive behaviours related to those responsive behaviours.

Grounds:

1. The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary assessment of the resident. There is no evidence of behavioural assessment related to mood and behavioural patterns on the resident's medical record. There is no documentation of potential triggers included in the plan of care related to the identified behaviours. A review of the Observation Record indicates that the resident exhibits some of the behaviours daily. There are no progress notes indicating that the resident has exhibited behaviours since May 2011. The MDS assessment is inconsistent with the narrative RAP for two assessments completed in 2011. Discussion with the Director of Care confirms that assessments are not consistently completed for residents with behaviours. (192)

2. The responsive behaviour plan of care for an identified resident is not based on an interdisciplinary

assessment of the resident that includes mood and behaviour patterns, identified responsive behaviours, potential behavioural triggers or variations in resident functioning at different times of the day. The plan of care indicates that the resident resists care - it is not specific as to the types of care resisted, or the time of day the resident is most resistant. A review of the resident's assessment completed in 2011 and notes contained in the Resident Assessment Protocol (RAP) indicate that the resident exhibits behaviours. Documentation in the progress notes does not indicate the presence of any behaviour since May, 2011. The plan of care does not reflect an accurate interdisciplinary assessment of the resident's responsive behaviours. (192)

This order must be complied with by:	Sep 12, 2011

Order #:	014	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order:

1 The licensee shall immediately have two identified residents assessed by the Registered Dietitian in relation to nutrition and hydration risks.

2 The licensee shall ensure that assessments by the Registered Dietitian are completed in a timely manner for all residents with a change in health condition.

Grounds:

1. The Registered Dietitian did not complete nutritional and hydration assessment for an identified resident when there was a significant change in the resident's health status on return from hospital in 2011.

a) An resident was identified with diagnoses of dysphasia, unstageable skin ulcer, refusal of meals, and dehydration. A review of food and the fluid intake records indicated refusal of meals and snacks most days. The documented food and fluid in take record for one month in 2011, indicates the resident's intake was less than ¼ or refusal most of the meals (19/24 days refused all meals). The Registered Dietitian completed a nutritional assessment while the resident was in hospital and the assessment did not include the resident's hydration status, assessment of food and fluid intake and an evaluation of the quantity of nutritional supplement ordered in relation to the resident's intake and requirement.

b) An identified resident returned from the hospital in 2011 with a diet texture change (downgrade in texture). Interview with registered nursing staff confirmed that a referral was made to the Dietitian for reassessment of the resident's nutritional status, including diet change. Review of the resident's health record and staff interview confirmed that the resident was receiving the downgraded texture and the resident did not have a diet assessment by the Dietitian to date July 26, 2011.

c) The dehydration and fluid maintenance triggered RAP completed in 2011 by the Registered nursing staff stated that an identified resident was refusing to drink and their daily fluid intake was below their required amount of fluids daily (1500 ml/day). The resident was identified to be at risk for dehydration. No plan of care was found for the resident in relation to dehydration and fluid maintenance. The resident's hydration status was not care planned with goals for minimizing and avoiding complications associated with dehydration. (159)

2. An identified resident returned from hospital in 2011, and a referral was made to Registered Dietitian. The contributing factors identified for referral were change in health status, new diagnosis of dysphasia, and a diagnosis of a urinary tract infection requiring antibiotics. Documentation in the resident's health record up to July 26, 2011 does not reflect that the Dietitian completed an assessment of the significant change in resident's health status i.e. urinary tract Infection, and risk for dehydration.

The Registered Dietitian did not complete a nutritional assessment for an identified resident in relation to nutritionally relevant abnormal blood work. No supportive documentation was found that the Dietitian had completed a nutritional assessment for abnormal blood values. (159)

This order must be complied with by:	Sep 02, 2011

Order #:	015	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order:

The licensee shall review and revise the plan of care when the plan of care has not been effective and consider different approaches to meet the care needs of all residents including:
a) An identified resident related to oral intake, weight change, and dehydration
b) An identified resident related to responsive behaviours
c) An identified resident related to bowel and bladder continence
d) An identified resident related to responsive behaviours
e) An identified resident related to fall prevention

Grounds:

1. The plan of care for an identified resident was not revised and different approaches considered when care set out in the plan of care was not effective. Documentation during the last quarter for the resident indicates behaviours have increased. Different approaches were not considered or included in the plan of

care although staff indicate that current interventions have not been effective in preventing or addressing the behaviours. (192)

2. The MDS assessment for an identified resident indicated a deterioration in continence levels. The Quarterly Continence Assessment indicates no change in urinary or bowel continence despite documentation on the Observation Record completed by Personal Support Workers that indicates that incontinence of bladder has been consistent, each shift daily. The frequency of incontinence of bowel has increased from 55% to 90% over two months. The plan of care for the resident has not changed and does not include interventions to address maintaining the resident's toileting needs related to bowel or bladder continence in relation to these changes. (192)

3. An identified resident was not reassessed and the plan of care revised and different approaches to care considered related to verbal and physical behaviours over a five month period. The current interventions for managing the resident's behaviour have not been successful. Two altercations with injury to co-residents have occurred in a 12 month period. The resident continues to have some interventions for responsive behaviours without any reassessment and consideration of new approaches for care. Staff indicate that the behaviours still exist, are unpredictable and remain high risk. (173)

4. An identified resident was not reassessed and the plan of care was not revised and different approaches considered when care set out in the plan of care was not effective in relation to recurring falls. The resident sustained 10 falls over a nine month period without revisions to the plan of care for falls prevention. Different approaches were not considered during this time period. (130)

5. The plan of care was not revised and different approaches considered when care set out in the plan of care was not effective for an identified resident related to oral intake. During interview and documentation review it was noted that this resident was refusing most meals and snacks. The resident has also had a significant weight loss over the last month. The resident receives a supplement daily. No other interventions have been added or considered. (159)

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

Order #:	016	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, 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.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order:

The licensee shall prepare and submit a plan to ensure that all staff receives training related to Long-Term Care Homes Act 2007, S.O. 2007, c.8, and s.76 (2) 1-10. This plan shall include short and long term actions to educate staff hired since July 1, 2010 and new staff prior to performing their duties. The plan shall be implemented. The licensee shall submit the plan electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **September 16, 2011**.

Grounds:

1. The licensee has not ensured that any person mentioned in subsection (1) does not perform their responsibilities before receiving training in the areas mentioned below:
   1. The Resident's Bill of Rights
   2. The long-term care home's Mission Statement
   3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
   4. The duty under section 24 to make mandatory reports
   5. The protections afforded by section 26
   6. The long-term care home's policy to minimize the restraining of residents
   7. Fire prevention and safety
   8. Emergency and evacuation procedures
   9. Infection Prevention and Control
   10. All Acts, regulations, policies of the Ministry, and similar documents, including policies of the licensee, that are relevant to the person's responsibilities before performing their responsibilities. [Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 76(2)1-10.]

i) A review of records provided for two of three newly hired staff since July 1, 2010 does not include a record of any Orientation Training received. A review of the Orientation Package does not include a copy of the Resident's Bill of Rights. The Personal Support Worker Nursing Department Specific Orientation Skills Passport does not include a review of the resident's Bill of Rights. Staff interviewed did not know of the Bill of Rights or indicated they had not received training on the Bill of Rights.(192)

ii) Two of three files of newly hired staff since July 1, 2010, did not include information related to training on the home's mission statement. Staff interviewed did not know what a mission statement was or indicated they had not received instruction on the mission statement. (192)

iii) A review of records provided for newly hired staff since July 1, 2010 provides no indication of training related to abuse or neglect of residents. During interview it was confirmed that some staff hired since July 1, 2010 received orientation to the home areas and perform their responsibilities without training on abuse, or before training on abuse and neglect of residents had occurred. (192)

iv) A review of the Orientation package provided does not include information related to mandatory reporting. Staff interviewed, which were hired since July 1, 2010 indicated they did not receive training related to mandatory reporting under section 24 before performing their responsibilities. Two of three

records reviewed for the training provided to newly hired staff does not include records of training related to mandatory reporting. (192)

v) The Orientation package provided by the home to new employees does not include information related to whistle-blowing protection, protection afforded by section 26 of the Act. Three of three records provided related to training for newly hired staff since July 1, 2010 does not include information related to whistle-blowing protection. Staff interviewed indicated that they were not aware of whistle-blowing protection. (192)

vi) The Orientation package provided by the home does not include the Minimizing of Restraints Policy. The Orientation Skills Passport does not include information related to the Minimizing of Restraints. Two of three records provided related to newly hired staff since July 1, 2010 does not include a record of training on the minimizing of restraints. Staff interviewed indicated they had not received training related to the minimizing of restraining prior to performing their responsibilities. (192)

vii) A review of records provided for newly hired staff since July 1, 2010 does not include a record of training on fire and safety. Staff interviewed indicated that they had not received training on fire prevention and safety before performing their responsibilities. (192)

viii) The orientation package used by the home does not include information related to emergency and evacuation procedures. A review of records provided for newly hired staff since July 1, 2010 does not include a record of training on emergency and evacuation procedures. Staff interviewed indicated they had not been trained on emergency and evacuation procedures. (192)

ix) Two of three records provided for newly hired staff since July 1, 2010 does not include a record of training related to infection prevention and control. Staff interviewed indicated that they had not received training on infection prevention and control before performing their responsibilities. (192)

x) The Orientation package provided by the home does not refer to the Long-Term Care Homes Act, or the Regulations. One checklist included in the package has not been updated and still refers to "Standards", a term used in the Long Term Care Facility Programs Manual. Three of three records provided for newly hired employees since July 1, 2010 does not include information related to training on the Act, regulations, policies of the Ministry and similar documents that are relevant to the person's responsibilities before performing their responsibilities. Staff interviewed indicated they were unaware of the Long-Term Care Homes Act or had not received training related to the Legislation. (192)

This order must be complied with by:	November 30, 2011

Order #:	017	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order:

The licensee shall prepare and submit a plan to ensure that all staff receive retraining in the areas of:

a) Fire prevention and safety
b) Emergency and evacuation procedures
c) Policy for handling complaints and the role of staff in dealing with complaints
d) Cleaning and sanitizing of equipment
The plan shall include short and long term actions as per intervals identified in the regulation.
The plan shall be implemented.
The licensee shall submit the plan electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **September 16, 2011.**

Grounds:

1. Interview with dietary, nursing and environmental staff confirmed that no recent training was received related to fire safety, evacuation, and the management of complaints or cleaning of equipment. The home is unable to provide documentation of training related to these topics conducted in the past year. (192)

This order must be complied with by:	November 30, 2011

Order #:	018	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order:

The licensee shall prepare and submit a plan to ensure that all staff who provide direct care to residents receive, as a condition to continuing to have contact with the residents, training in the areas set out in section 76(7) of the Act.
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in Accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations

The plan shall include short and long term actions to ensure training is provided as per the intervals provided for the regulation. The plan shall be implemented.

The licensee shall submit the plan to Inspector Asha Sehgal at asha.sehgal@ontario.ca by **September 16, 2011.**

Grounds:

1. A review of training documentation and interview with Personal Support Workers (PSW), Recreational Aides, and Dietary Aides confirmed that no training related to mental health issues, dementia, behaviour management and palliative care were offered within the past year. (192)

2. The licensee has not ensured that all staff has received training related to the licensee's written procedures for handling complaints and the role of staff in dealing with complaints before performing their responsibilities. [Long-Term Care Homes Act 2007, S.O, 2007 c.8, s.76(7)6]

The orientation package used by the home does not include information related to the procedures for handling complaints. Staff interviewed were not aware of the policy related to dealing with complaints or indicated they had not received training on the policy. Three of three records provided for staff hired since July 1, 2010, did not include a record of training related to the complaints process. (192)

The licensee has not ensured that all staff have received training relating to the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities before performing their responsibilities.

During interview with the Assistant Director of Care it was confirmed that training related to equipment relevant to the staff member's responsibilities does not occur until the staff member is on the home area. Staff interviewed indicated that they did not receive training on the safe and correct use of equipment before performing their responsibilities. Two of three records provided related to newly hired staff did not include training records related to the safe and correct use of equipment. (159)

This order must be complied with by:	November 30, 2011

Order #:	019	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order:

A. The licensee shall review and revise the following policies, protocols, procedures, strategies or systems to ensure that they are in compliance with and implemented in accordance with applicable requirements under the Act.
a) Written Complaints Policy

b) Verbal Complaints Policy
c) The complaint record
d) Meal and Snack Time Policy
e) Policy for minimizing restraints
f) Recreational and Social Activities Department policies
g) Abuse and Neglect Policy
h) Policy for Pneumococcus, Diptheria and Tetanus.
i) Falls Prevention and Management

B. The licensee shall train all staff on the revised policies.

Grounds:

1. The resident care manual located at the first floor nurse's station does not contain a "Falls Prevention & Management" policy. Policy number B-5 located in the Resident Care Manual has not been updated, as stated by the DOC. According to the DOC, the revised "Fall Prevention & Management" policy revised November 2009, is not readily available to staff. r.8.(1) (130)

2. The licensee's policies related to Written and Verbal Complaints are not in compliance with requirements under the Act. The policy titled Verbal Complaints dated November 2010 is not in compliance with requirements under the Act. (192)

3. The policy related to Minimizing of Restraints is not in compliance with requirements under the Act. (130)

4. Policy V11-G-10.00 called Abuse and Neglect of a Resident is not in compliance with requirements under the Act.

5. The home does not have policies in place in relation to the following: pnemococal, diptheria, and tetanus immunization. (130)

6. The Complaint Record maintained for the home and referred to in the Written Complaint policy is not in compliance with requirements under the Act. (192)

7. A review of the policy and procedure manual of Recreational and Social Activities department and interview with the Director of Activation confirmed that the current policy, protocol and procedure manual has not been revised since 2006 and is not in compliance and accordance with applicable requirements under the Long Term Care Homes Act. (159)

8. The policy related to Meal and Snack Times (# MS-40.00(b)) dated February 2010 is not in compliance with requirements under the Act. (159)

This order must be complied with by:	November 30, 2011

Order #:	020	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order:

1. The licensee shall prepare and submit a plan to ensure that the home furnishings and equipment are maintained in a safe condition and in a good state of repair. The plan shall be implemented. The plan shall be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **September 26, 2011.**

Grounds:

1. The licensee has not ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair in relation to the following:
[Long-Term Care Homes Act, 2007, S. O. 2007, c. 8, s. 15(2)c]

a) Chairs in all common areas and resident's rooms are chipped, damaged, upholstery worn/torn, stained and cannot be properly cleaned. (173)

b) Baseboards in the third floor dining room and a specified room are torn and pulled away from the wall creating a hazard for residents related to accessibility and tripping hazard. Heat registers in the third floor dining room and resident tub room are damaged with covers bent and falling apart, exposing the unit to residents. West hallway on third floor heat register is damaged, appears to be coming apart with cover hanging open, exposing the unit to residents. I a specified room - wall heating register cover falling off, exposing the unit to the residents in the room. (173)

c) Walls have been damaged and not fully repaired in specified rooms. Resident washroom on third floor has wall damage that has not been fully repaired. (173)

d) Window curtains are missing hooks and therefore hanging off tracks. The curtains are not able to be fully closed to provide privacy or darkness. (173)

e) Electrical outlet cover on west wing of third floor is loose, there are open holes in the wall where the air conditioner has been installed with possible wiring exposed to residents.(192)

f) Toilet tank lid missing in specified room on July 7, 2011. Toilet leaking in resident/public washroom on first floor on July 7, 2011 (130)

g) Shower chair in east shower room on third floor is worn and unsafe for resident use due to lack of stability.

h) Resident common washroom on 3rd floor - drywall has water damage in three locations, wooden panel is rough along the bottom edge. (173) The mirror is noted to be loose and a potential hazard for

falling. (130)

i) Windows in main floor dining area are in poor repair with condensation in-between the two panes of glass. This impairs residents view to the outside area while dining, due to the windows appearing cloudy. (173)

This order must be complied with by:	December 1, 2011

Order #:	021	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Order:

The licensee shall prepare and submit a plan to ensure that all residents within the home receive care that promotes continence, and ensures that residents are clean, dry and comfortable. The plan shall be implemented.
The plan shall be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by **September 16, 2011.**

Grounds:

1. The licensee did not ensure that the following interdisciplinary programs were developed and implemented in the home: A continence care and bowel management program that promotes continence and ensures that residents are clean, dry and comfortable. [O. Reg. 79/10 s. 48(1)3]

a) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident is not routinely toileted to promote continence. Their continence status has changed from continent to totally incontinent over an eight month period. (192)
b) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident had been instructed to use their incontinent product instead of being toileted even though the resident is able to ask for assistance and aware of the need to be toileted. (192)

c) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident was noted to smell of urine during interview.

d) The continence care program that promotes continence and ensures that residents are clean and dry was not implemented for an identified resident. The resident was noted to have urine odour during interview and observation. (192)

e) It was acknowledged by the Director of Care that a program is in place, but the program is ineffective at ensuring that residents are clean, dry and comfortable. No efforts have been made as a result of this knowledge by the home.

f) During interview with Personal Support Workers it was identified that some residents require the application of a brief and a liner so that "they do not need to be changed as frequently". This information was confirmed by multiple staff. (192)

This order must be complied with by:	September 23, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

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

and the

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

Fax: 416-327-7603

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

Orders 002, 003, 004, 006, 007, 008, 009, 010, 012, 013, 014, 015, issued on the 29th day of August, 2011. Orders 016 – 021 issued on the 7th day of September, 2011. Directors Orders 001, 005, 011 Issued on the 21st day of October, 2011	
Signature of Inspector:	Deborah Neville for Asha Sehgal
Name of Inspector:	Asha Sehgal
Service Area Office:	Hamilton Service Area Office

Ontario

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

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

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	
Order Type:	□ Amend or Impose Conditions on License Order, section 104 □ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of License Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2011_071159_0012
Licensee:	King Nursing Home LTD
LTC Home:	King Nursing Home, 49 Sterne Street, Bolton, ON, L7E 1B9
Name of Administrator:	Janice King

Background:
This order, Director Order CO # 001, substitutes for Inspector Order CO # 001 that was originally served on the above named licensee on August 29, 2011 as a result of a Director's review requested by the licensee on Sept. 24, 2011 and in accordance with s. 163 (1) of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.

Order:	CO # 001

To King Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:
LTCHA, 2007 S.O., C.8, S.9.(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;
(b) the goals the care is intended to achieve; and
(c) Clear directions to staff and others who provide direct care to the residents. 2007, c.8, s.6(1).

Order:
The license shall immediately ensure that the plans of care for the following residents are reviewed and revised to provide clear direction to staff as identified below:

a) resident related to weight changes and activities of daily living
b) resident related to nutritional needs and safety risks
c) resident related to oral care and continence
g) resident related to continence, pain and mobility
h) resident related to transfers and oral care.

Grounds:

1. The plan of care for resident indicates that resident brushes their teeth independently with set up. Interview with staff and a record review indicates that resident requires total assistance for oral care and will not complete the task independently. Resident has no identified toileting routine included on the Plan of Care, staff interviewed gave conflicting reports related to when resident should be toileted. (192)

2. The plan of care of resident related to oral care indicates that staff are to provide oral care – there are no directions related to the frequency care is to be provided, or how it is to be provided. The plan of care for resident does not provide clear direction related to transfers as it identifies that two staff are required for the sara lift as resident is unable to participate although it also indicates that resident uses a Maxi-lift for transfers at all times. (192)

3. The plan of care for resident under Mobility indicates that all physiotherapy is on hold, although during interview it was identified that resident is currently receiving active and passive range of motion. During interview it was identified that resident requires positioning with their feet elevated to promote comfort. Resident indicated in interview that feet and legs cause discomfort and interrupt their sleep. Positioning for comfort is not addressed on the plan of care. Under bowel and bladder continence the plan of care indicates that resident is to be toileted before meals, after meals, at bed time and as necessary. Staff interviewed indicated that resident had their incontinence product changed in the morning after meals and with bedtime care. The plan of care does not reflect care the resident is receiving.

4. The care plan for resident provides conflicting information related to the resident's swallowing and the diet ordered. Resident requires one bed rail raised while in bed and a crash mat on the floor, however, as a result of a fall in July 2011, two bed rails/restraints were ordered for this resident while in bed. Directions for staff were not updated on the plan of care to reflect this change. (130)

5. The plan of care of resident does not identify clear goals, objectives and specific strategies for weight loss.

   The plan of care dated April 8, 2011 states "to achieve a personal weight loss goal of 25 lbs over the next three months". Review of the progress notes documented by the Registered Dietician April 6, 2011, states that the resident's personal weight loss goals are unsafe. No direction is provided for dietary interventions for safe weight loss.

This order must be complied with by:	October 28, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

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

and the

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

Fax: 416-327-7603

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

Issued on this 21 day of October, 2011.	
Signature of Director:	Karen Slater
Name of Director:	Karen Slater

Ontario

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

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

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	
Order Type:	☐ Amend or Impose Conditions on License Order, section 104 ☐ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2011_071159_0012
Licensee:	King Nursing Home LTD
LTC Home:	King Nursing Home, 49 Sterne Street, Bolton, ON, L7E 1B9
Name of Administrator:	Janice King

Background:
This order, Director Order CO # 002, substitutes for Inspector Order CO # 005 that was originally served on the above named licensee on August 29, 2011 as a result of a Director's review requested by the licensee on Sept. 24, 2011 and in accordance with s. 163 (1) of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.

Order:	CO # 002

Ontario

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

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

To KING NURSING HOME LIMITED you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:
O.Reg 79/10, s. 8. (1) – Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O.Reg 79/10, s. 8. (1)

Order:
The licensee shall prepare, submit and implement a plan to ensure that the following required procedures, strategies or systems are complied with:

a) Oral Care
b) Continence/Incontinence Guidelines for care
c) Mechanical Lifts/Lifting Policy
d) Pain Management
e) Abuse and neglect of a resident

The plan shall be submitted electronically to Inspector Asha Sehgal, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at asha.sehgal@ontario.ca by October 31, 2011.

Grounds:

1. Policy and Procedure VII-E-10.0 called Abuse and Neglect of a resident – actual or suspected, states that: "All staff and volunteers will receive in-service education on the topic of abuse and neglect and the reporting of abuse and neglect."

   The home has provided only one in-service education session related to abuse, neglect and whistle-blowing protection in the past year. There were only 22 staff present for this in-service education. No other attempts to repeat the education have been made and ensure that all staff have received the required training.

   Pain and Symptom Assessment and Management Protocol Policy # VII-G-70.00 dated July 2011 requires that registered staff complete and document a pain assessment of initiation of a pain medication, or when there is a change in condition with pain onset, distress related to behaviours or facial grimacing.

   Resident is on an analgesic for pain related to immobility, post-surgery. Resident is currently

experiencing pain related to a disease – no assessment has been completed related to ongoing pain.

Resident is on analgesic related to joint pain and ulcers on the feet. This pain continues and the resident states that it often keeps them from sleeping. No further assessment has been conducted related to this pain in the feet.

The policy indicates that a 24 hours Pain and Symptom Monitoring Tool is to be used when a scheduled pain medication does not relieve the pain, when pain remains regardless of interventions, pain medication is changed, or an empiric trail of analgesics is started. Interview with the Director of Care indicates that the 24 hours Pain and Symptom monitoring tool is not in use in the home. (192).

2. The home's policy on the use of Mechanical Lifts/Lifting Policy number J-1 is not complied with. The plan of care for resident indicates that 2 staff are to interlock arms with resident and support them during transfer. Resident participates sometimes with the transfers. The home's policy indicates that "the preferred method of lifting will be conducted with the use of mechanical lifting devices, including one-person, two person and three person lifts (not transfer)". Staff are not to attempt to lift any weight over 40 lbs and adherence to proper body mechanics is a must. Resident's current weight is 52.4 kg (155.5 lbs) significantly higher than the 40 pounds indicated in the policy. Staff were observed on July 26, 2011 lifting resident from the floor to the bed. (192).

3. The licensee did not ensure that their Policy for Oral care was complied with by care staff on the floor. Policy #B 35 called Personal Hygiene – Oral Care: Policy and Guidelines indicates that staff are to provide residents the opportunity to perform oral care twice a day. If the resident is not able to perform this care themselves then they will be assisted by care staff. Oral care was inspected for resident for two days of the inspection. The resident did not receive oral care on either day. Staff confirmed the lack of care during interview in July 2011 stating that the resident was too sleepy to perform the care. The resident was observed to have food debris in their teeth on several occasions and was noted to have mouth odour on one occasion. (173).

4. The policy "Promoting Continence" Policy # VII-E010.00 requires that Registered staff will complete all documentation regarding the resident's level of bladder/bowel continence or incontinence and planned interventions in the appropriate areas of the resident's record such as Progress notes, quarterly summaries and annual reviews, medication records, flow sheets and care plan.

   The plan of care related to incontinence of bowel and bladder for resident does not reflect the assessed level of continence or incontinence of the resident or the planned interventions required for the resident. Staff were not clear on the continence care needs for the resident or when care should be provided.

   During interviews staff indicated that residents are checked and changed upon waking and after meals. One Personal Support Worker indicated that residents are checked and changed or toileted every 2-3 hours. Observation of resident in July 2011 – the resident was not checked, changed or toileted before lunch and for a period of 2 hours and 45 minutes during observation (1100 hours – 1345 hours). Evening staff interviewed indicated that residents were checked, changed or toileted before supper, and at bedtime.

Ontario

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

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

This order must be complied with by:	November 15, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) In accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

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

and the

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

Fax: 416-327-7603

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

Issued on this 21 day of October, 2011.	
Signature of Director:	Karen Slater
Name of Director:	Karen Slater

Ontario

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

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

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	
Order Type:	☐ Amend or Impose Conditions on License Order, section 104 ☐ Renovation of Municipal Home Order, section 135 X Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2011_071159_0012
Licensee:	King Nursing Home LTD
LTC Home:	King Nursing Home, 49 Sterne Street, Bolton, ON, L7E 1B9
Name of Administrator:	Janice King

Background:
This order, Director Order CO # 003, substitutes for Inspector Order CO # 013 that was originally served on the above named licensee on August 29, 2011 as a result of a Director's review requested by the licensee on Sept. 24, 2011 and in accordance with s. 163 (1) of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.

Order:	CO # 003

To KING NURSING HOME LIMITED you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: O.Reg 79/10, s, 52. (2) – Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O.Reg 79/10, s, 52. (2)
Order: The licensee shall ensure that: a) training is provided to staff on the use of the clinically appropriate pain assessment/instrument, determined as appropriate for use in the home, and b) that a monitoring program is put in place to ensure the clinically appropriate pain assessment instrument is used by staff in all cases where a resident's pain is not relieved by initial interventions.
Grounds: 1. Resident had a fall in July 2011 and sustained an injury, analgesic given post fall was not effective in relieving the pain. Resident was not assessed using a clinically appropriate assessment instrument specially designed for this purpose. Resident received Tylenol 650 mg for pain post treatment for the injury in July 2011. The pain was not relieved – no pain assessment was conducted using a clinically appropriate assessment tool. Discussion with the Registered practical Nurse confirms that no post fall pain assessment was conducted related to the pain sustained by resident. Discussion with the Director of Care confirms that there is no clinically appropriate assessment instrument in use at the home at this time. (192)

This order must be complied with by:	November 30, 2011

Ontario

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

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

and the

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

Fax: 416-327-7603

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

Issued on this 21 day of October, 2011.	
Signature of Director:	
Name of Director:	Karen Slater