Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_267528_0023	031165-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

CYNTHIA DITOMASSO (528), DARIA TRZOS (561), HEATHER PRESTON (640), SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 28, 31, and November 1, 2, 3, 4, 8, 9, 10, 14, 15, 16, 17, 2016.

The inspection was done concurrently with complaint inspection log #'s 032788-15 and 027249-16 related to resident care; critical incident system log #'s 007140-15, 008699-16, 016364-16 021992-16, 023588-16 and 031789-16 related to falls, 000286-16 ,005923-16, 017174-16 and 019032-16 related to responsive behaviours, 000324-16 related to unexpected death, 006872-16, 016788-16, 018923-16, 026550-16 and 028784-16 related to abuse, 010234-16 and 019921-16 related to injury of unknown origin; follow up log # 030163-16 related to neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Office Manager, Director of Care (DOC), Assistant Directors of Care (ADOC), Director of Dietary Services, Scheduling Coordinator, Director of Programs, Environmental Services Manager (ESM), Physiotherapist (PT), Registered Dietician (RD), Food Service Supervisor, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary staff, housekeeping and laundry service staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **11 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_240506_0018	528

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents were protect from abuse by anyone.

A. Resident #065 was transferred with the assistance of one staff, and required assistance with transferring from chair to bed. The resident received an anti-inflammatory as a regularly scheduled medication. At the end of February 2016, resident #065 complained of pain that was not controlled with the regularly scheduled pain medication several times, for which they received an as needed (PRN) pain medication intervention. Due to the noted increase in pain, the resident was referred to physiotherapy services for further assessment and intervention. Nine days later, the resident stated their pain was from being abused by PSW #121, related to rough handling when assisted back to bed. Furthermore, the PSW then verbally threatened the resident not to tell anyone what had occurred. The resident was transferred to hospital for treatment. The home completed an internal investigation and determined that an act of abuse occurred after taking the statement of resident #065. The home's policy titled, "Prevention of Abuse & Neglect of a Resident", policy #VII-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and freedom from abuse and neglect. The organization has a Zero Tolerance policy for resident abuse." Interview with DOC confirmed that PSW #121's actions did not comply with the home's anti-abuse policy and confirmed that resident #067 was not protected from abuse by anyone. (619)

B. Resident #064 had bladder incontinence, and required extensive assistance with personal hygiene tasks. On an identified day in September 2016, resident #064 requested assistance from PSW #152 . Interview with resident #064 indicated that PSW #152 was rough with the resident and refused to provide continence care and treatment cream to the resident. A review of the home's internal investigation notes determined that the resident was not physically injured from the incident but interview with resident #064 indicated that they felt saddened by the actions of the care provider. Interview with DOC confirmed that the resident was not protected from abuse by anyone in the home. (619) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A. On an identified day in April 2015, resident #050 fell in their room which resulted in an injury. Interviews with PSW #121, registered staff #131 and the Physiotherapist, indicated that the resident had a device in place as an one intervention in place for falls. Interview with PSW #121, who attended to the fall, stated that the device was applied on the day of the fall. The written plan of care was reviewed and did not include the device, as an intervention for falls. It was however, added to the written plan of care after the fall. The ADOC #001 confirmed that the device was in place prior to the fall in April 2015, and

should have been in the written plan of care. The licensee failed to ensure that there was a written plan of care that set out the planned care for this resident in relation to the falls prevention strategies. (561)

B. Resident #017 was observed in bed with two assist bed rails in the transfer position and the use of bed rail pads was observed. The PSW #109 confirmed that the resident required to have two assist bed rails with pads applied. The written plan of care was reviewed and did not indicate that the bed rail pads were being used for the resident. The home's policy called "Bed Rails", policy number VII-E-10.20, revised June 2016 indicated "document in resident's progress notes the application of bed rail pads and update the care plan". The DOC confirmed that the resident was required to have the bed rail pads and that the written plan of care did not indicate that the pads were being used. The licensee failed to ensure that the written plan of care set out the planned care for the resident. (561)

C. A. Resident #047 was at high risk for falls related to falling frequently and had a number of interventions in place to prevent them from falling. In June 2016, a post fall indicated staff were not to leave the resident along in their room unsupervised. The interview with the Physiotherapist indicated that the staff were not to leave the resident alone in the room as they were getting up from the bed and wheelchair which caused many falls. The written plan of care was reviewed and indicated that this intervention was not included in the written plan of care. The ADOC #001 confirmed that this intervention should have been included in the written plan of care. (561) [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A. In November 2016, Resident #017 was observed in bed with two assist bed rails applied in the guard position. The interview with PSW #109 and registered staff #105 confirmed that the resident required to have the assist bed rails applied in bed for bed mobility and comfort. Both of the staff members confirmed that the terminology used in the home when assist rails were being applied was "down" as they swing downward on the bed. The current written plan of care was reviewed and stated that the resident had two bedrails up when in bed for bed mobility and comfort. The interview with the DOC confirmed that when the assist rails were applied the care plan should have stated two bedrails down when in bed and confirmed that the terminology was not clear. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. When resident #011 was admitted to the home the Registered Dietitian (RD) assessed the resident as having a low Body Mass Index (BMI) and ordered an identified nutritional supplement at the morning snack pass. In an interview resident #011 indicated that after they moved rooms six months later, they stopped receiving the nutritional supplement at the morning beverage pass. A review of the resident's meal record sheets in October and November 2016 indicated that the resident had not received the nutritional supplement as ordered. Interview with the RD confirmed that the resident's BMI as of November 2016, was low and confirmed the resident still required the nutritional supplement and interview with FSS, confirmed that the resident's move was not updated in the food services electronic management system and that labels were not created for the resident's nutritional supplement. (619)

B. On October 29, 2016, resident #016 complained of discomfort and was assessed by the physician. New orders included but were not limited to, specimen collection. Review of the plan of care two days later revealed that the physician order had not been processed, checked or implemented. Interview of RN #113 confirmed that the order written for resident #016, was not transcribed and the specimen was not collected and sent as ordered. Interview with the DOC confirmed that the order was not transcribed within 24 hours of being written, as outlined in policy "VIII-F-10.30, Physician's Orders", revised January 2015. The DOC confirmed that it was the expectation of the home that staff transcribed and implemented the order within 24 hours of receiving the order. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan, related to the physician order for urine specimen collection. (640)

C. In August 2016, resident #080 was re-admitted from the hospital and required the assistance of one staff for transfers and mobility. The re-admission PT assessment identified that the resident required a device applied for safe ambulation and transfers. Nine days later, family filed a complaint concerned that the device had not yet been provided. Investigation notes and interview with registered staff #131 confirmed that the resident was not provided the the device until ten days after they were recommended for safety. (528)

D. Resident #044's plan of care indicated that the resident required two person assistance for personal hygiene, bathing, transferring and toileting. In February 2016, the

resident was provided a shower with the assistance of two PSWs. The resident started to have responsive behaviours during the shower, at which time, one of the PSWs left the shower room to call for assistance leaving the other PSW alone with the resident. While the PSW left, the resident slid from the chair and landed on the floor. The resident did not sustain injuries after the fall. The interviews with the two PSWs indicated that the call bell was pressed first and then one of the PSWs left to get help. The interview with the registered staff #114 confirmed that for the safety of the resident and staff, the PSWs should have waited until help arrived. The resident's plan of care was not provided to the resident as specified in the plan. (561)

E. The review of the health care records for resident #045, indicated that in May 2016, the resident sustained an injury of unknown origin. The plan of care, in effect at the time of the incident, stated that resident #045 required extensive assistance from two staff for the provision of personal hygiene, turning and repositioning. The interviews with staff #134 and #125, as well as the home's investigation notes into the incident identified that resident #045 was being provided care by one PSW. Interview with the DOC confirmed that the staff were not providing care as identified in the plan of care when resident #045 sustained the injury of unknown cause. (561) [s. 6. (7)]

4. The licensee failed to ensure that the resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #047 was at high risk for falls related to falling frequently and had a number of interventions in place to prevent them from falling. The review of the written plan of care and interviews with staff indicated that the written plan of care was not updated when the following care needs changed:

i) In May 2016, an intervention to prevent injuries when falling was identified as no longer required. The written plan of care was reviewed and not updated when the intervention was discontinued. The current written plan of care stated the resident refused the intervention. The ADOC #001 confirmed that the intervention was no longer required and the plan of care had not been updated to reflect the change in the resident's care needs.

ii) In June 2016, the resident was documented as using a wheel chair for mobility. The current written plan of care under the behaviours indicated that the resident wandered. The ADOC #001 was interviewed and confirmed that this was no longer valid. Resident did not wonder as they were currently using a wheelchair for transport and required staff to assist them in pushing the wheelchair.

iii) In September 2016, resident #047 had a fall in their room, requiring two devices to be placed on either side of the bed. However, the current written plan of care was reviewed and indicated that the resident only had one device in place and was not updated to include the additional device. The interview with the ADOC #001 confirmed that the written plan of care should have been updated with the new intervention.

iv) Interview with PSW #124 and registered staff #100 indicated that the resident was assessed to require two staff assistance for transfers with a hoyer lift in July 2016 and two staff assistance for toileting. Review of resident #047's plan of care, indicated that resident was independent for toilet use with one staff supervision. The ADOC #001 confirmed that the written plan of care was not updated to reflect the change.

B. Resident #014 was observed in bed with one assist rail applied in the transfer position and one assist rail in the guard position. The health care records were reviewed and the written plan of care indicated that the resident used two bed rails up in bed for bed mobility and comfort. The interview with the PSW # 115 and registered staff #105 confirmed that the resident was to have one assist rail applied while in bed. The physician's order dated October 26, 2016, indicated that one full rail and one assist rail were discontinued and PASD bed rail (one assist) up when in bed for bed mobility and comfort was ordered. The written plan of care was not revised to reflect the new order. This was confirmed by the DOC.
The licensee failed to ensure that the written plan of care was revised when the resident's care needs changed. (561) [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Resident #062 required extensive with all activities of daily living including personal hygiene and showering tasks due to dementia and poor mobility, and had a history of displaying responsive behaviours. Interview with PSW staff #128 indicated that the resident required assistance from more than one person for showering for a long time before the responsive behaviour episode in May 2016, that caused the resident to be anxious, and display responsive responsive behaviours towards staff. A review of the resident's written plan of care last updated after the incident, indicated that the resident required two staff for all showering activities. Interview with PSW #128 indicated that PSW staff often had to call for extra assistance from registered staff to intervene on the

residents behaviours during the provision of personal care. Interview with RPN #105 indicated that the frequency of resident #062's responsive behaviours had increased in the last three months, and confirmed that more than one staff was required to assist resident #062 to shower prior to the incident, and indicated that no changes to the resident's care plan had been made to reflect the need for two staff assistance. Interview with DOC confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that there is a written plan of care for each resident that sets out the planned care for the resident
ii. that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident
iii. that the care set out in the plan of care is provided to the resident as specified in the plan
iv. that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

Resident #014 was observed in bed with one assist rail applied in the transfer position and one assist rail in the guard position. Interviews with the PSW #115 and registered staff #105 confirmed that the resident was to have one assist rail applied while in bed. In October 2016, one full rail and one assist rail were discontinued and a new order was written for one assist bed rail up when in bed for bed mobility and comfort. Review of the plan of care included a bed rail assessment from August 2016, indicated that the resident was using two bed rails up when in bed, and a new assessment was not completed with the change in bed rail use. The DOC confirmed that the resident was not re-assessed when the bed rails were changed. Furthermore, interviews with ADOC #001 and DOC revealed that the home did not consider the rotating assist rail in the transfer position an active bed rail, and therefore, bed rail assessments did not include whether or not the resident required rotating rails in the transfer position. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

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

On November 4, 2016, at 0845 hours, resident #089 was observed with a device that appeared to be loose. Upon further inspection, the belt was approximately six fingers breadth away from the resident's body, and the strap appeared twisted. Interview with RPN #100 confirmed that the device was too loose and when PSW #122 attempted to adjust the belt, they were unable, to move the adjusting strap. Review of the plan for the resident identified that the resident required the device for safety and was physically able to remove the belt. Interview with ADOC #002 confirmed that the device should fit snug to the resident's body according to manufacturer's instructions, and six fingers breadth was too loose. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff plan provided a mix that was consistent with residents' assessed care and safety needs and that met the requirement set out in the Act and this Regulation.

A. On November 2, 2016, one PSW staff member was not replaced for the day shift on Meadows home area. Between 1100 and 1200 hours, a second PSW left due to injury. As a result the home was left with two PSW staff, a nursing student and the RPN.

i. At approximately 1140 hours, the call bell for resident #082 was alarming. Registered staff #114 confirmed that PSWs were aware the resident needed assistance; however, they were short staffed and were trying to provide the resident with continence care as soon as they could. Resident #082 reported that they had already been waiting too long, was unsure of how long, and they expressed their frustration and dissatisfaction when the PSWs had to work short. The plan of care for resident #082 identified that the resident was incontinent of bladder and bowels and required the assistance of two staff when the resident requested continence care. Interview with PSW #150 and #151 confirmed that the resident had been waiting for assistance with continence care but since they were short, the resident could not be provided with continence care

immediately.
ii. At approximately 1200 hours, resident #83 was observed to be in bed. Interview with the resident identified that they had not yet received their morning shower and staff had not yet assisted them out of bed. Review of the plan of care identified that the resident was scheduled to receive a shower that morning, had specific care in bed, and then was assisted with two staff and a mechanical lift to their wheelchair. The resident expressed frustration with the fact that is was so late and they remained in bed. Interview with RPN #114 confirmed that PSW staff were working short and that they were behind with care, since they had to help the PSWs with resident care.

B. The nursing daily staff schedule outlined that four PSW staff were listed as part of the complement for day shift for each home area, three PSW staff for evenings shift for each home area, two PSW staff for nights on the locked unit, and one PSW staff on nights for the remaining home areas plus two floating PSWs. From May to October 2016, review of the nursing daily staff schedules for each home area revealed an increase in occurrences that PSW staff had been working with less staff than the complement suggested.

i. May 2016 – one to one for resident #019 was not staffed on evening shift four times and a home area worked with one less PSW three times.
ii. June 2016 – PSW staff worked short on one home area three times and on nights one time.
iii. July 2016 – PSW staff worked short one person on days four times and on nights two occasions, one to one was not implemented on eight occasions
iv. August 2016 – PSW staff worked short one person twice on day shift, once on evening shift, and once on nights; one to one was not implemented on nine occasions.
v. September 2016 – PSW staff worked short one person nine times on day shift and twice on nights, furthermore, there were an additional two night shifts documented that staff worked short two persons
vi. October 2016 – PSW staff worked short one person 29 times on day shift, three times on evening shift, and twice on night shift. One to one not implemented on three occasions.

Interview with PSW staff in the home, including union steward, scheduling coordinator and the ED confirmed that since September 2016, that the home was not replacing the complement on days, and for a period of time on nights, in an attempt to recover budgetary costs. Furthermore, due to decreased CMI, the home would permanently reduce the complement on one home area to three PSWs on day shift. In an interview,

the ED was asked how the home was ensuring that the current staffing process was meeting the needs of the residents, to which they denied any knowledge indicating otherwise.

B. Review of the complaints log revealed in September 2016, a resident voiced concerns about the regularity of the home working short PSW staff and how resident's care was being affected, specifically wait times for care. The resident was no longer in the home and could not be interviewed; however, review of the complaints log noted that the home reassured the resident that even though staff are short, care of the resident should not be affected.

C. Review of Resident Council minutes from October 2016, identified concerns from residents that there was not enough help in the dining rooms to feed residents who need it and short staffing was creating longer wait times for meals. Responses were provided by the home outlining the following:

i. that volunteers had been trained and would be used
ii. that the home was working within budgetary constraints related to the Ministry of Health funding
iii. that the home had a program in place to prevent absenteeism

D. The following month Resident Council documented concerns that there were not enough staff on nights, specifically related to concerns about not enough staff to get up early. The home's response included reviews of plans of care and identified those residents that wanted to get up earlier in the morning and ensured that night staff would do so.

E. The Long-Term Care Home Service Accountability Agreement (L-SAA) LTCH Level-of-Care Per Diem Funding Policy, last amended January 2013, outlined expenditures under the the Nursing and Personal Care envelope including but not limited to the cost of direct care staff and defined direct nursing and personal care as assistance with the activities of daily living, including personal hygiene services, administration of medication, and nursing care.

During the course of the inspection, PSW staff were observed putting resident's clean laundry away. Interview with PSW #117 and #135 confirmed that on evenings PSWs were responsible for putting residents' clothes away and PSW #117 stated that they came in early (before the start of their shift) to get all the laundry put away. The home's

PSW Job Routine – Evenings 1500-2300 hours listed as part of their tasks from 1515 hours they were to put the residents clothes in their room from the laundry cart, which was not include under the Nursing and Personal Care envelope. Interview with the ED confirmed that the task of putting laundry away was a regular part of the job routine for PSWs on evenings and no funding adjustments had been made as a result.

F. The staffing plan did not always meet the needs of residents with responsive behaviours, when one to one interventions were not implemented when staff were unavailable. The plan of care for resident #019 identified that the resident had ongoing responsive behaviours. In March 2016, one to one was initiated for the resident on days and evening shifts and was increased to include nights in July 2016.
On two identified days in July and August 2016, the one to one for resident #019 was not scheduled, as a result, the resident had unwitnessed falls on both shifts, with pain post fall documented for one fall. Interview with registered staff #139 confirmed that the home did not implement one to one monitoring required for resident safety, and as a result, the resident had falls.

G. Review of the plan of care for resident #085 revealed that the resident required total assistance of two staff with bathing. Point of Care (POC) documentation for the resident showed the resident did not receive a scheduled bath on an identified day in October 2016, and it was not provided at a later date. Interview with PSW #135 confirmed that the home was working one PSW short that day, and they were unable to bath all the residents; therefore resident #085 only received one bath that week.
ii. On an identified day in November 2016, Meadows home area worked with one less PSW on day shift and, at approximately 1130 hours, a PSW left the floor due to injury. Interview with resident #083 at 1150 hours, revealed that they had not been provided morning care, had a shower, or assisted out of bed; due to staffing shortages. Interviews with PSW #150, #151, and registered staff #114 confirmed that the home was working short and, therefore, they were unable to shower the resident. The plan of care for resident #083 identified that they required two staff assistance with a shower twice weekly, and required mechanical lift for transfers. Interview with registered staff #114 confirmed that bathing from November 2, 2016, was not rescheduled and the resident did not receive two scheduled bath days that week.
iii. From October 22 to 28, 2016, PSW staff worked short on Summer home area on day shift six out of seven days. POC documentation identified that resident #086, #090 and #091 all required the assistance of one to two staff and preferred a shower on their scheduled bath day.; however, residents #090 and #091 received bed baths on their bathing days for the week the home area worked short and resident #086 received one

bed bath and one shower. Interview with resident #086 confirmed that although they did not miss their bathing days when staff worked short, they were not getting their preference and often was offered a bed bath only. Interview with PSW #129 and #135 confirmed that when PSW staff were not replaced, they tried their best to given residents their scheduled bath; however, if a resident required extensive assistance or they were running behind, a bed bath was given.

H. It was also identified during the inspection that in September 2016, the home had hired seven PSW staff and five registered staff to address the availability of staff; however, the home continues to not replace one PSW per unit on day shift as instructed

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff plan provides a mix that was consistent with residents' assessed care and safety needs and that meets the requirement set out in the Act and this Regulation, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. Review of the plan of care for resident #085 revealed that the resident required total assistance of two staff with bathing. Point of Care (POC) documentation for the resident showed the resident did not receive a scheduled bath on an identified day in October 2016, and it was not provided at a later date. Interview with PSW #135 confirmed that the home was working one PSW short that day, and they were unable to bath all the residents; therefore resident #085 only received one bath that week.

On an identified day in November 2016, Meadows home area worked with one less PSW on day shift and, at approximately 1130 hours, a PSW left the floor due to injury. Interview with resident #083 at 1150 hours, revealed that they had not been provided morning care, had a shower, or assisted out of bed; due to the staff shortages. Interviews with PSW #150, #151, and registered staff #114 confirmed that the home was working short and, therefore, they were unable to shower the resident. The plan of care for resident #083 identified that they required two staff assistance with a shower twice weekly, was a mechanical lift for transfers. Interview with registered staff #114 confirmed that bathing from the identified day in November 2016, was not rescheduled and the resident did not receive two scheduled baths that week. (528) [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A. The Bladder and Bowel Continence Assessment from May 2016, indicated that resident #016 had urinary incontinence which had worsened over the past six months. Bowel continence was identified as once a day or less and was worsening over the past six months. Section H identified the resident as aware of urge to void and defecate, aware of appropriate place to toilet, able to find the toilet, aware to understand reminders/prompts, aware when urine being passed and was motivated to be continent. Section J – Summary-Continence Status was incomplete but did include treatment options of personal hygiene and the use of continence products. The Minimum Data Set assessment from July 2016, coded the resident to be occasionally incontinent of bowel and frequently incontinent of bladder. The written plan of care did not direct staff when and how to toilet the resident under both the bowel and bladder incontinence focus. The

focus "moderate risk for falls" directed staff to toilet resident before and after meals, before going to bed and when needed for safety. Observation of resident home area by Inspector on two identified days in November 2016, from 0900 to 1200 hours and 1200 to 1330 hours, identified no pattern of toileting or regularly offering to toilet resident #016. Interview of resident #016; revealed that the resident self-toileted often and stated was able to clean themself after. The resident stated they rarely had a bowel movement in the brief and was able to pull the brief down and up, but occasionally required help. Interview of PSWs #116 and #112 confirmed no knowledge of any scheduled times to toilet resident #016. Interview of RN #114 confirmed no knowledge of any scheduled times to toilet the resident. RN #114 stated resident #016 to be toileted in the morning and resident often toileted self.
Therefore the licensee failed to ensure the resident who was incontinent had an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented. (640) [s. 51. (2) (b)]

2. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Since August 2016, the plan of care for resident #080 directed staff to provide gentle persuasion and cuing to toilet hourly when awake and to monitor and report wet floor when awake.
On an identified day in November 2016 from 0815 to 1000 hours , the resident was observed continuously. The resident was taken to the dining room with one person assistance without being offered or reminded to use the bathroom. The resident was not provided with cueing to toilet until after breakfast at 1000 hours.
On an identified day in November 2016, from 1600 to 1830 hours, the resident was observed wandering the unit and was in and out in their room, urine was noted on the floor in the bathroom doorway. At 1715 hours, the resident was assisted to the dining room without being offered or reminded to use the bathroom and remained in the dining room until 1830 hours.
Interview with PSW #132 confirmed that the resident required ongoing monitoring hourly and should be reminded to toilet at that time, including before and after meals.
Observations in November 2016, revealed that the resident was not provided the assistance for managing continence, as required in the plan of care. (528) [s. 51. (2) (c)]

3. The licensee failed to ensure that residents were provided with a range of continence care products that:

(i) were based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promoted resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence.

A. The plan of care for resident #023 identified that the resident was incontinent of bladder and bowels but had some control present and required extensive assistance of one staff for toileting. Review of the Resident Profile Worksheet for Lake home area revealed that the resident wore a specific type of continent products, which were not provided by the home. Interview with PSW #123 confirmed that the resident wore the continent products daily, which were paid for and provided by the resident's family not the home. Interview with the family of resident #023 stated that the resident was comfortable in the ype of product and since the home did not provide that kind of product, they had been paying out of pocket for the continent product. The family of resident #023 confirmed that the resident would use the same type of continent product supplied by the home, if available.

B. The plan of care for resident #084 identified that the resident was incontinent of bladder with some control present and was able to transfer self, however, required extensive assistance of one staff with some aspects of toileting. Interview with registered staff #104 confirmed that the resident wore a specific type of continent product during the day that were supplied by the resident's family, not the home, and the resident toileted themselves at times. Interview with resident #084 confirmed that they wore their own supply of continent products daily. They also stated that the home provided the resident with different option but not the type of products that she required and therefore, their family was instructed to buy the continent product. Resident #084 confirmed that they would use a continent product supplied by the home, if available.

C. Throughout the course of the inspection, pull ups were not observed to be available to residents on the floors or in the storage area where continence care products were stored. The ESM, who ordered continence care products, confirmed that pull ups were not included in what he ordered and any "special products" are ordered by the ADOC. Interview with the DOC revealed that pull up products were not supplied to residents "unless they ask for them".

D. The plan of care for resident #048, identified that the resident was continent for

bladder and bowels and was able to self toilet but required supervision due to unsteady gait. The resident used a continent product for comfort provided by the resident's Substitute Decision Maker (SDM) as outlined in the Resident Profile Worksheet. Interviews with PSWs #115 and #117 confirmed that the resident wore a continent product which were paid for and provided by the resident's SDM, not the home. They had also confirmed that the home did not provide the type of product to residents.
The interview with the resident's SDM stated that the resident wound not wear anything else other than that type of continent product. The SDM also indicated that the type of product was not presented as one of the options for continent products supplied by the home, therefore they had to pay out of pocked for for the product, since the resident's admission to the home. The SDM of resident #048 confirmed that the resident would be open to trying the same type of product provided by the home, if available. (561) [s. 51. (2) (h)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented
ii. that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence
iii. residents are provided with a range of continence care products that are based on their individual assessed needs, properly fit the residents, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence wherever possible, and are appropriate for the time of day, and for the individual resident's type of incontinence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose

A. In May 2016, resident #060 complained of discomfort to a member of the registered staff, and review review of the resident's health record, did not include a pain assessment at the time of the complaint. Two days later, the resident fell and six days later was diagnosed with an injury. The following month the resident was re-ordered an anti-inflammatory for pain on an as needed basis, related to the post fall injury, and no pain assessment was completed in relation to the onset of pain and when the pain medication was administered. Interview with RPN #120 indicated that when there was a change in the resident's pain level that registered staff were required to complete and document a pain assessment for the resident. A review of the home's policy titled "Pain & Symptom Management", policy # VII-G-30.10, last revised January 2015, stated that "Registered staff will conduct and document a pain assessment electronically on initiation of a pain medication or PRN analgesic". Interview with DOC confirmed that registered staff are required to complete and document a pain assessment with the use of a clinically appropriate assessment tool when a resident requires medication for break through pain, and confirmed that this was not completed. (619)

B. In January 2016, resident #019 fell and immediate assessment of the resident identified no injuries were present. Later that evening, the resident began to have discomfort, as reported by family to registered staff. The following day signs and symptoms of injury were documented by registered staff. Review of the plan of care identified that the resident was cognitively impaired and did not include a completed clinically appropriate assessment instrument for pain until six days after the fall, after an injury was confirmed. Interview with ADOC #001 confirmed that a pain assessment for cognitively impaired residents should have been completed, when there was a new onset of pain, as outlined in the "Pain & Symptom Management Policy # VII-G-30.10". (528)

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A. The plan of care for resident #019 identified that the resident had ongoing responsive behaviours. In March 2016, one to one was initiated for the resident on day and evening shifts and was increased to include nights in July 2016.
i. In August 2016, resident #019 had an altercation with another resident resulting in injury. Interview with PSW #125 and registered staff #129 confirmed that the one to one staff member took a break and, therefore, one to one monitoring was not implemented at the time of the incident.

ii. In September 2016, resident #019 had an unwitnessed fall with injury. Review of the progress notes revealed that the one to one was not present at the time of the incident. Interview with DOC confirmed the one to one was not implemented at the time of the incident as required in the plan of care.
iii. On two identified days in July 2016 and August 2016, the one to one for resident #019 was not scheduled, as a result, the resident was found on the floor on both shifts; pain was documented following the fall one fall. Interview with the Scheduling Coordinator confirmed that there was no staff available to fill the one to on the two identified shifts. (528)

B. Plan of care for resident #041, identified that resident had responsive behaviours and one of the interventions in place was to have one to one at all times to prevent such behaviours. In June 2016, while one to one was with the resident, the resident left the dining room during lunch time and eloped from the building. The interview with the one to one PSW #118 indicated that during lunch time while they were to be providing one to one to resident #041, the registered staff had asked them to assist with feeding another resident. The resident left the dining room and did not return. The investigation notes and interview with the DOC confirmed that the one to one PSW was not monitoring the resident during lunch time as they were assisting to feed another resident.
The licensee failed to ensure that strategies developed for resident # 041 were implemented when the resident was able to leave the building. (561) [s. 53. (4) (b)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A. In 2016, resident #080 displayed an increase in responsive behaviours and in May 2016, was assessed using the dementia observation system (DOS). In May 2016, the DOS charting was only completed on nights. As a result, Behavioural Support Ontario (BSO) suggested all shifts complete DOS for seven days in June 2016. Review of DOS charting from June 2016, revealed that staff failed to document their observation consistently every 30 minutes. Interview with registered staff # 100 confirmed that the DOS assessments were not documented every 30 minutes, as required. Interview with BSO staff #139 confirmed that PSWs often fail to document their DOS assessments, making it difficult to analyze the residents behaviours.

B. In July 2016, resident #080 had a procedure and was not to rub their eyes. Due to the

resident's cognitive impairment the home initiated DOS monitoring every 30 minutes, to ensure the resident did not touch their eyes. DOS charting was not consistently completed after the procedure, as confirmed by registered staff #131. (528)

C. Resident #019 had ongoing responsive behaviours and altercations with residents, as a result, the resident was referred for psychogeriatritian consult and DOS charting was initiated following high risk incidents. Review of DOS charting from March 2016, which was not consistently completed on night shift even thought progress notes documented that the resident spent nights wandering. Interview with registered staff #100 confirmed that DOS charting was incomplete and BSO staff #139 confirmed that PSW staff do not documented their 30 minute checks as required for DOS assessments. (528) [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible
ii. that for each resident demonstrating responsive behaviours 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including,
i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surface

During the course of the inspection the following fabric covered furniture was observed to be stained:
i. In the common resident lounge near the entrance, one red chair and one plaid chair were stained on the arm rests and seat cushions.
ii. In the lounge on Meadows home area, one pink chair was stained on the seat cushion.
iii. In the north lounge on Garden home area, one blue chair was stained on the seat cushion.
iv. In the North multi-use therapy room on Garden home area, two yellow chair were stained on the seat cushions.
v. Rooms 221, 223 and 227 lounge chairs were stained on the seat cushions.
vi. In the south lounge on Summer home area, one green chair and one purple chair had stains on the seat cushions.
vii. In the north lounge on Lake home area, three blue chairs were stained on the seat cushions.
viii. In the south lounge on Cottage home area, three green chairs were stained on the seat cushions.

Review of the "Schedule of Operation: Daily Cleaning Duties", dated August 2015, and

"Deep Cleaning of Common Areas Policy # XII-D-10:90" last revised January 2015, directed housekeeping staff to complete a general damp dusting of furniture daily and deep cleaning weekly. Interview with the ESM revealed that housekeeping staff were to do daily checks and cleaning of furniture in the home and when required would complete a deep clean; furthermore, if the furniture could no longer be cleaned it would be taken off the resident home areas. Interview with housekeeping staff#159 identified that all staff were to check the furniture and report any furniture that needed to be cleaned. Housekeeping staff #159 revealed that the home had a fabric cleaner for cleaning stained chairs and reported that they were notified of a stained chair in a resident's room about a month ago, but it had not yet been cleaned. Housekeeping staff #159 also reported that they were unaware of any other furniture that needed deep cleaning, and had not used the fabric cleaning machine since entering the role in October 2016. The home's policies and procedures for monitoring and cleaning fabric furnishings in both resident rooms and common areas were not implemented. (528) [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for cleaning of the home, including,
i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surface, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

On November 10, 2016, LTC Inspector #561 observed the morning medication pass between 0730 hours and 0820 hours, on the Summer home area. Registered staff #120 was administering medications to resident #049 and the LTC Inspector noticed that a medication was sitting in a medication cup in the designated slot for the resident. The registered staff #120 indicated that they had pre-poured the controlled substance for the resident. The registered staff had also indicated that they pre-poured all controlled substance medications for all residents on this unit for the morning administration. Incident was immediately reported to the DOC who confirmed that pre-pouring of medication including but not limited to, narcotics, was unacceptable. (561) [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On November 16, 2016, on the Garden home area, the LTC Inspector found four rings in ziploc bags that belonged to residents in the narcotic bin in the medication cart along with the controlled substances. The RPN #105 was not aware of the legislative requirements and indicated that they stored these items for safekeeping. The DOC confirmed that these items should not have been stored in the medication cart. (561) [s. 129. (1) (a)]

2. The Licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On Thursday November 10, 2016, at 1000 hours, a medication cart was observed in the hallway of the second floor Summer living area. Inspector observed RPN #120 inside a resident's room administering medication; upon checking the medication cart the inspector determined that it was unlocked and was able to open the medication drawers. Interview with RPN #120 indicated that the medication cart should be locked at all times when not in active use by the registered staff to maintain the security of the drug supply. Interview with DOC confirmed that registered staff are responsible for maintaining the security of the medication cart and the drugs stored inside, and confirmed that the medication cart should have been locked. (619) [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

On an identified day, during the course of the inspection, a Dementia Observation System (DOS) monitoring record was observed taped to the nursing station desk on the third floor Lake living area. The DOS monitoring sheet was visible to the inspector, residents, and visitors on the unit and included the personal health information of resident #067. This personal health information included resident #067's full name, room number and DOS monitoring values from the same month. Interview with RPN #121 indicated that taping DOS monitoring records to the nursing desk was a common practice in the home to remind staff to document their behavioural observations. Interview with DOC confirmed that the resident's personal health information was not protected. (619) [s. 3. (1) 11. iv.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's "Falls Prevention Policy #: VII-G-30.00", last revised January 2015, directed registered staff that following their post falls assessment they were not to notify physician if suspicion or evidence of injury and or arrange for immediate transfer to hospital.

i. In January 2016, resident #019 had a fall. Post falls and pain assessments were conducted and determined no injury was present. Later that day, the family of the resident reported to registered staff that the resident new discomfort and the physician was not notified. Instead, a note was left for the physician. Signs and symptoms of injury were documented by registered staff the following day and an assessment by the PT reported the resident had ongoing discomfort. The physician did not assess the resident until three days later, when an x-ray was ordered, and the resident was diagnosed with an injury, five days after the fall. Interview with ADOC #001 confirmed that the staff should have notified transferred the resident to hospital or notified the physician of the injury post fall, as required in the home's policy. (528)

B. The MediSystem Pharmacy policy Prescribing - Physician Orders - 03-01-20, last reviewed June 2014, outlined that medication orders should include but not limited to, dosage, frequency, route of administration, and dosage form.

The plan of care for resident #080 identified that the resident was continent of bowels and in October 2016, after the third day with no bowel movement, the family refused the home's bowel protocol to administer a suppository and requested oral medication instead. Review of the physician's order read the medication dose frequency and route. However, review of the electronic medication administration record (eMAR) did not include the frequency of when the medication should be give. Interview with the registered staff #131 confirmed that eMAR order did not specify frequency and the DOC confirmed that all medication orders are to include the frequency, as per policy. (528)

C. On October 28, 2016, during the initial tour of the home a total of four home areas were observed to have unlabelled used personal hygiene products in the Spa Shower and Spa Tub rooms. In the third floor Lake home area a used washcloth was observed left on the spa tub. In the third floor Cottage home area, one used unlabelled mens electric razor was identified. In the second floor Garden home area, two unlabelled black hairs combs, one unlabelled red toothbrush were identified. In the first floor Meadows home area one unlabelled used air of nail clippers were identified. Housekeeping staff confirmed that these items should be labelled in accordance with the home's infection prevention and control policy. The home's policy titled, "Cleaning, Disinection and

Sanitization", policy # V6-030, revised August 2014, directed staff that "personal care items will be labeled with the resident's name and room number". Interview with DOC confirmed that staff are responsible for labelling hygiene products and confirmed that staff did not participate in the home's infection prevention and control practices. (619) [s. 8. (1) (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy VII G-10.00 Prevention of Abuse and Neglect of a Resident, last revised January 2015, directed the home to immediately report incidents to the MOHLTC, including but not limited to, misuse or misappropriation of a resident's money. The policy outlined the following indication of financial abuse; if the power of attorney (POA) for finance refused to spend money on required care needs.

In February 2015, missed payments for resident #087 began occurring monthly. Review of the plan of care identified that the resident's family member had control of the resident's finances. It was not until nine months later, in November 2015, that the home notified the police and the MOHLTC. Interview with the Office Manager confirmed that they entered the role in September 2015, and the home did not immediately report suspicion that the resident's family member was misuing resident #087's finances, even though monthly payments continued to be missed, until November 2015. (528) [s. 20. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

A. In August 2016, the POA for resident #063 was notified of a new area of altered skin integrity. Review of the plan of caree identified that area worsened the following day and a skin and would assessment was completed at that time, however, was not completed on initial assessment of altered skin inteigrty. A review of the home's policy titled, "Skin & Wound Care Management Protocol", policy # VII-G-10.80, last revised April 2016, stated that, "with a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears of wounds, registered staff will conduct a skin assessment". Interview with PSW #137 indicated that it is the responsibility of PSW staff to inform the registered staff of any changes in a resident's skin condition and that this was communicated to registered staff in August 2016. Interview with registered staff #158 indicated that when there is a change in the status of a resident's skin condition that registered staff were to complete a skin and wound assessment. Interview with DOC confirmed that the skin assessment was to be completed the same day the new area of altered skin integrity was observed. (619)

B. In March 2016, a PSW staff had created an alert on Point of Care (POC) indicating that a new skin issue was identified for resident #045. RPN #105 indicated that the staff were expected to complete an assessment of any new altered skin integrity using a clinically indicated tool in Point Click Care (PCC).
The ADOC #001 and ADOC #002 confirmed that when a resident is exhibiting a new skin integrity the registered staff are expected to assess the resident's skin and complete a skin assessment using a clinically indicated tool in PCC. Health care records were reviewed for resident #045 and identified that a progress note was made the next day, about the new altered skin integrity; however, an assessment using a clinically appropriate tool designed for skin and wound assessment could not be found in PCC. The home failed to ensure that the resident exhibiting altered skin integrity received a skin assessment using a clinically appropriate tool that was specifically designed for skin assessment. (561) [s. 50. (2) (b) (i)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

The home's "Distribution of Linen - Laundry Policy # XII-1-20.10", last revised January 2015, identified that linen requirements will be written on the Linen Count Sheet for each resident home area to ensure that an adequate supply of clean linen is available to the resident home areas at all times.

The Linen Cart Quotas for Resident Home Areas directed laundry staff to supply a laundry cart twice a day, once on days shift and evening, containing the following linen:
i. Face cloths - 40
ii. Hand towels - 32
iii. Bath towels - 12
iv. Pillow cases - 12
v. Bottom sheet - 12
vi. Top sheet -8
vii. Comforter - 4

On November 9, 2016, the evening PSWs expressed concern that they did not receive the quota for face, hand, and bath towels; however, observations were not made of the cart to count the linen.
On November 16, 2016, at 1510 hours the evening cart for Meadows resident home area was counted which included 22 face cloths, 24 hand towels, and eight bath towels. Interview with laundry staff #146 confirmed that the linen cart for Meadows was not stocked as required. (528) [s. 89. (1) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure to make a report in writing to the Director setting out the following with respect to an incident: a description of the incident, including the date and time of the incident.

Resident #061 had a fall with injury in June 2016, and acquired injuries that required treatment at hospital. A review of the critical incident report log #2911-000020-16 indicated that the incident occurred on different identified date in June 2016. A review of the resident's health record indicated and interview with DOC confirmed that the date of submission of the critical incident was not accurately reported to the Director. (619) [s. 104. (1) 1.]

Issued on this 11th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DARIA TRZOS (561), HEATHER PRESTON (640), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2016_267528_0023
Log No. / Registre no:	031165-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 3, 2017
Licensee / Titulaire de permis :	2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michele MacKenzie

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To 2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall do the following:

The licensee shall ensure all residents, including resident #064, and #065 are protected from abuse by anyone and are not neglected by the licensee or staff.

Grounds / Motifs :

1. This non-compliance had a severity of "actual harm/risk", with a scope "isolated" and an ongoing history of noncompliance of a CO issued related to neglect in July and September 2016.

A. Resident #065 was transferred with the assistance of one staff, and required assistance with transferring from chair to bed. The resident received an anti-inflammatory as a regularly scheduled medication. At the end of February 2016, resident #065 complained of pain that was not controlled with the regularly scheduled pain medication several times, for which they received an as needed (PRN) pain medication intervention. Due to the noted increase in pain, the resident was referred to physiotherapy services for further assessment and intervention. Nine days later, the resident stated their pain was from being abused by PSW #121, related to rough handling when assisted back to bed. Furthermore, the PSW then verbally threatened the resident not to tell anyone what had occurred. The resident was transferred to hospital for treatment. The home completed an internal investigation and determined that an act of abuse occurred after taking the statement of resident #065. The home's policy titled, "Prevention of Abuse & Neglect of a Resident", policy #VII-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and freedom from abuse and neglect. The organization has a Zero Tolerance policy for resident abuse." Interview with DOC confirmed that PSW #121's actions did not comply with the home's anti-abuse policy and confirmed that resident #067 was not protected from abuse by anyone. (619)

B. Resident #064 had bladder incontinence, and required extensive assistance with personal hygiene tasks. On an identified day in September 2016, resident #064 requested assistance from PSW #152 . Interview with resident #064 indicated that PSW #152 was rough with the resident and refused to provide continence care and treatment cream to the resident. A review of the home's internal investigation notes determined that the resident was not physically injured from the incident but interview with resident #064 indicated that they felt saddened by the actions of the care provider. Interview with DOC confirmed that the resident was not protected from abuse by anyone in the home. (619) (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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