Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2014	2014_214146_0006	H-000322-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), IRENE PASEL (510), ROBIN MACKIE (511)

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): March 24, 25, 26, 27, 28, 31, April 1, 2, 3, 2014.

Follow-up inspections H-000964-13, H-000965-13 and H-000242-14 were completed and are included in this RQI inspection report.

During the course of the inspection, the inspector(s) spoke with the administrator, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) coordinator, registered dietitian (RD), food service manager (FSM), environmental manager, program manager, resident relations coordinator, administrative assistant, staffing coordinator, registered staff, Personal Support Workers (PSW's), housekeeping staff, laundry staff, dietary aids, Family Council representative, Resident Council representative, residents and family members.

During the course of the inspection, the inspector(s) toured the home; reviewed policies and procedures, resident health records, staffing schedules, meeting minutes and observed resident care.

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

(A) In March 2014 resident #034 was observed in the hallway, sitting in a chair, with body parts exposed. The PSW confirmed the exposure of the resident was inappropriate and was a violation of the resident's rights to dignity.
(B) In March 2014, during a meal service, two PSW's were observed to be sitting at the residents' dining tables engaged in personal conversations that did not include resident interaction. This was supported through a Resident Council interview which identified staff as frequently having personal conversations that excluded the residents, during meal service. In April 2014, during the provision of resident care by two PSW's, the PSW's were observed to be engaged in a conversation of a personal nature, using profanity, that excluded the resident. Interview with the ADOC confirmed participating in personal conversations during the provision of resident care does not recognize the resident's individuality nor respects the resident's dignity and is not the expectation of the home.

2. The licensee did not ensure that the rights of residents were fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
(C) In March 2014, dried food residue was observed on resident #080's face several hours after a meal service. In March 2014 food was observed on resident #110's face several hours after a meal service. In March 2014 at resident #071 was observed sitting in a chair in the hallway with dried food on the resident's face and clothing several hours after a meal service.
(D) In an interview in March 2014, the family of resident #080 reported an incident that the family had witnessed on an unspecified date in March 2014. The family rang the resident's call bell because the resident had expressed the need to be taken to the bathroom. The call bell was answered 15 minutes later by a staff member who, according to the family member, denied the request and told the resident it was too close to lunch and the resident had to go to the dining room. The resident's care plan indicated that constipation was a problem focus. The resident's right to be cared for in a manner consistent with his or her needs was not respected. There was no indication on the health record of the incident but a registered staff member stated he/she had vague recollection of hearing about the incident previously.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.
As confirmed with the FSM in April 2014,
(A) Resident #201's weights recorded in Point Click Care (PCC) computer system indicated an 8.5% weight change over three months. A dietary referral was sent by nursing to dietary in December 2013. The dietary referral was not completed; the resident's weight change was not assessed, and actions and outcomes were not evaluated.
(B) Resident #202's weights recorded in PCC in January and February 2014 indicated a change of 11.5% over one month, a 13.1% over three months and a 13.1% over six months . A dietary referral for the weight changes was not initiated. The resident's weight change was not assessed, and actions and outcomes were not evaluated.

Additional Required Actions:

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

WN #3: 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 of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and (b) complied with
(A) The "Continence Bowel – Prevention of Constipation Home Specific Procedure, V3-240.1, dated August 16, 2013", was not followed. The policy required Registered staff to give 125 ml of prune juice if a resident had not had a bowel movement for three days, to administer 30 ml of Milk of Magnesia (MOM) if no bowel movement for three days, along with a referral to the RD for constipation and physiotherapy for mobility, a Dulcolax suppository if no bowel movement for four days and a fleet enema if no movement for five days, along with notification to the MD.
(i) Resident #053 had experienced constipation and did not receive medications as prescribed by the physician on a date in March 2014.
(ii) Resident #053 had a bowel movement on a date in March 2014, and not again until four days later. A review of the progress notes and eMAR identified that the policy for prevention of constipation was not followed.
(iii) The same resident did not have a bowel movement for five days later in March. A review of the progress notes and eMAR identified that the policy for prevention of constipation was not followed
(iv) Resident #071 had experienced constipation in March 2014 on three separate

occasions and did not receive medications as prescribed by the physician.

(B) The "Documentation Standards", V3-570, dated April 2013 policy was not followed. The policy required that documentation related to each event, action, or assessment must: document precisely, accurately, clearly and concisely.
(i) A review of the clinical record for resident #026 indicated that the resident received 125ml prune juice on three dates in March 2014, however, according to the eMAR, the resident did not receive prune juice on those dates. The Registered staff confirmed that the documentation was not accurate.
(ii) In March 2014 meal service was observed and it was noted that resident #204 did not consume any of the lunch meal. Documentation, however, indicated on the intake flow-sheet and "look back report" that the resident had consumed 76-100% of the meal. Interview with the staff who completed the documentation confirmed that the staff did not actually observe the resident's intake and had asked another staff and therefore, could not verify the accuracy of the documentation.
This inspection did not include a follow up inspection related to the previous order for not complying with the home's hypoglycemia policy because no episodes of hypoglycemia had occurred since the previous order, therefore, it remains outstanding.

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident.
(A) In March 2014 resident #009 was observed receiving a specific intervention. The care plan contained no directions to staff related to the specific intervention. [s. 6. (1) (c)]

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.
(A) Resident #076 was observed receiving specific interventions. The resident's assessments in MDS, the resident assessment protocol (RAP) and another assessment tool used specifically for one of the interventions contained differing information regarding the resident's assessed needs.
In April 2014, the RAI coordinator confirmed that the assessments and the MDS assessment were not integrated or consistent with one another. [s. 6. (4) (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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

(A) The home's staffing schedules were reviewed for the month of March 2014 and random other months. There was no RN in the home on July 19, 2013 for night shift, July 17, 2013 from 1500 to 2000, December 10, 2013 from 1500 to 2000 hours, March 4, 2014 from 1500 to 1900 hours and March 22, 2014 from 0700 to 1500 hours. This information was confirmed by the staffing coordinator. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #6: 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 did not ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails were addressed, including height and latch reliability.
(A) Three resident beds were observed to have specialized mattresses in place in addition to bilateral quarter bed rails in the raised position. Residents were noted to be sleeping in two beds with bed rails raised on two dates in March 2014. A record review of the facility entrapment inspection sheet, dated October 9, 2013, indicated beds with the specialized mattresses were not assessed. Interview with the DOC confirmed the bed system, specifically the specialized mattresses with side rails, was not evaluated nor the residents assessed specifically for minimizing risks to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails with air flow mattress. [s. 15. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #7: 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 did not ensure that the staffing plan:
(a) provided for a staffing mix that was consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(A) In April 2014, resident #510 was sitting in the hallway an hour and a half after breakfast with a dietary clothing protector in place. The resident reported that the resident had not been assisted out of bed until 0900 for breakfast that was scheduled to begin at 0830. The resident stated that he/she drank the juice and ate only the cold cereal for breakfast; that he/she did not touch the toast or any other food that needed hand contact because staff had not washed the resident's face and hands before breakfast. The resident requested to go to bed at 1010. Resident was assisted to bed by staff at 1055 hours. The PSW stated the floor was short-staffed by one PSW and there was not enough time to get residents washed and to breakfast by 0830. The PSW stated that only half of the 20 residents on that wing were taken in to breakfast by 0900 on this date and the other ones were there by 0930. The DOC confirmed that the unit was short one PSW and all attempts to replace a sick call had been exhausted. The staffing on this date was not meeting resident needs.
(B) A review of the worked schedules for March 2014 revealed that between March 1 and 24, 2014, there were only seven days when the home was fully staffed with PSW's on all shifts. In the same time period, there were 27 eight hour shifts where the

home was short a PSW. On March 14, 2014, the home was short 2 PSW's on the day shift. On March 17, 2014, the home was short 2 PSW's on days and 1 on evenings. On March 23, 2014, the home was short 2 PSW's on day shift. This information was confirmed by the scheduling coordinator.
(C) On March 22, 2014, the dining rooms in the home did not serve the soup on the menu at lunch time because of short staffing. This information was confirmed by the FSM, a dietary aid and Resident Council.
(D) Resident Council Vice-Chair interview indicated that staff frequently work short and as a result breakfast is served late every morning. On all dates of this inspection, residents were observed being wheeled into the dining room for 0830 breakfast up to 0915. On March 28, 2014, three residents were observed to be still in bed at 0900 who normally would be up for breakfast.
(E) Resident Council minutes of February 2013 indicated that residents were concerned about the short staffing and breakfast starting 20 minutes late every day. The home responded to the concern and stated the home was trying to hire more staff.
(F) Resident #500 and #501 both indicated that their baths were not consistently offered when scheduled for Sundays because staff were working short.
(G) A resident submitted a complaint record to the home in June 2013 stating that the home was short a nurse and a PSW on night shift and the situation caused potentially "unsafe and dangerous" conditions. This information was confirmed by the complaint log review and the Resident Council interview.
(H) The family of resident #110 submitted a written complaint in September 2013, indicating that the family rang the call bell for assistance for the resident who required continence attention. After waiting for 15 minutes, the family looked for a staff member. The staff responded that the staff person was working alone on the floor. The complaint record indicated that the family stated when the call bell was activated, staff rarely answered in a timely manner.
(I) A complaint record indicated that in October 2013, a family complained because a resident was in pyjamas at 1600. The PSW told the family that it was to save time. On a date in March 2014, inspectors observed three residents sitting in dining and lounge areas in pyjamas at 1600 hours. On April 1, 2014, the ADOC indicated that certain identified residents wished to be in pyjamas early and it was in their plan of care. However, none of the residents observed in pyjamas were those identified by the ADOC nor did their plans of care direct staff to put them into night clothes early.
(J) Family Council minutes of January 2014 indicated concern that staff were working short. The DOC indicated that the home is actively recruiting for more PSW's online and with PSW schools.

(K) Residents Council minutes of March 2014 indicated that morning personal care routines are being started late on the Heritage wing and breakfast is consistently starting late. The residents felt that the home did not have enough staff on the floor in the few hours before breakfast. Residents and staff confirmed this.
(L) A family member of resident #080 reported to an inspector that the home seems frequently short staffed and call bells are often not answered for 15 to 20 minutes. The POA cited the following as an example: on an unspecified date in early March, the family rang the call bell because the resident needed to go to the bathroom. They waited at least 15 minutes for staff to answer the bell. The staff member then told the resident and family that the resident could not be taken to the bathroom because it was too close to lunch and he/she must go to the dining room. The resident's plan of care states that constipation is a problem.
(M) PSW's were interviewed on various units and asked the question "how often do you work short of your normal staffing number?" The replies were as follows: about six days per week; nine days per month at least; almost every weekend.
(N) The Administrator confirmed in April 2014 by telephone that the home does not have a plan to aid nursing and personal care staff that addresses situations when working short. The registered staff are expected to give direction to personal care staff when needed. [s. 31. (3)]

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 staffing plan:
(a) provides 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, and (d) provides 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, to be implemented voluntarily.***

WN #8: 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 did not 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) Resident Council minutes and an interview with the Resident Council Acting Chair indicated concerns that not all residents were receiving two baths per week. Two of three cognitively alert residents interviewed on March 31, 2014, indicated that they have not consistently had their two baths per week in the time period between January 1, 2014 and present, even though two baths per week are their preference. The residents could not give specific dates but indicated that weekends were a problem because of short-staffing on weekends. Resident #501 stated that some of the resident's twice weekly baths have been missed by staff since January 1, 2014 but was unsure of an exact number. When asked if the bath was made up or offered a day later, the resident stated no. Resident #500 stated he/she does not consistently get two baths per week and estimates that six baths have been missed since January 2014. The residents could not give specific dates but indicated that weekends were a problem because of short-staffing on weekends. A review of documentation with the ADOC revealed that the documentation indicated that the baths had been done. The home suggested that perhaps the residents were not being truthful. The ADOC indicated that bathing has been audited regularly by checking the staff's documentation. [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 #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that, residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required by the resident.

(A) In March 2014 resident #009 and resident #802 were not provided with assistance from staff when their meals were placed in front of them. Both residents had to wait for assistance up to 20 minutes. Their health records indicated both required assistance from staff. [s. 73. (2) (b.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that where a resident was being restrained by a physical device under section 31 of the Act: 1. that staff only applied the physical device that had been ordered or approved by a physician or registered nurse in the extended class.

(A) In March 2014 at 1015 hours, the resident was observed with a specific intervention in place which required the order of a physician or a RN EC. There was no order in place for the intervention.
This information was confirmed by registered staff and the ADOC. [s. 110. (2) 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 where a resident is being restrained by a physical device under section 31 of the Act: 1. that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the program.

(A) In March 2014 it was observed, during a meal service, that two of the front line staff cleared the dirty dishes from the dining tables and proceeded to serve out the second serving of the meal without hand washing. This was again observed in April 2014 where one staff was noted to clear the dirty dishes and then provide the second course without washing hands in between.
(B) In April 2014 during medication administration, a nurse was observed to administer a parenteral medication to resident #800 without washing hands before or after the medication administration. A second nurse, in April 2014 was observed to administer a medication to resident #801 without washing hands before of after the administration.
In an interview, the home's infection control nurse confirmed the above practice was not supportive of the homes infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home and equipment were kept clean and sanitary.
(A) In March 2014, an inspector observed that: the floor in a common tub room was soiled; the tub legs and the legs of the mechanical lift were soiled; the seat of the commode chair in the attached bathroom was soiled with fecal material and sitting over a toilet bowl soiled with feces. The Environmental Manager confirmed that daily cleaning and cleaning after each use was the home's policy and expectation. The staff indicated that the commode was not used often so had not noticed the soiling.
(B) In March 2014, a resident room was observed to have dirt and dust on the floor along the baseboards especially worse behind the door to the hallway. There was also a dark pink fluid dried spill on the floor beside the resident's bed. Three days later, the same dust, dirt and dried spill were present. The Environmental Manager confirmed that the resident's floor should have been cleaned daily. [s. 15. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home received fingernail care, including the cutting of fingernails.
(A) In March 2014, resident #80 was observed to have long fingernails with dirt caked under them. The health record indicated that the resident had a tub bath several days prior. There is no indication or documentation related to fingernail care. According to the ADOC, it is the home's expectation that morning routine care includes washing of hands and face every morning before breakfast and the bath includes fingernail care. [s. 35. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, (b) cleaned as required.
(A) In March 2014 and also in April 2014, resident #080 was observed to be wearing soiled eyeglasses.
(B) Family of resident #080 indicated via an interview that eyeglasses are frequently noted to be dirty when family visits the resident. [s. 37. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee of a long-term care home did not ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.
(A)In April 2014 resident #803 was observed an hour and a half after the meal service to be sleeping in a tilt wheelchair. The tilt wheelchair was in the upright, 90 degree position and the resident was hunched over at the waist, leaning downward and forward, posing a risk for a fall from the chair. The resident's health record identified that the resident's rest routine required the resident be put to bed to rest after the meal service. Registered staff interviewed confirmed the resident rest routine was not supported and identified that the resident needed to be put back to bed after breakfast. [s. 41.]

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 of a long-term care home did not ensure that a 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 that was specifically designed for skin and wound assessment and was reassessed at least weekly by a member of the registered nursing staff.
(A) Progress notes and the written plan of care for resident #006 identified an alteration in skin integrity in March 2014. Further review of the health record and an interview with the registered staff confirmed that a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not completed and the wound was not assessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (i)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not ensure that licensee sought the advice of the Residents Council and the Family Council in developing and carrying out the satisfaction survey.
(A) The family member interviewed as a representative for Family Council stated that families had no input into the questions or development of the Family and Resident Satisfaction Survey.
(B) The Residents Council Vice-Chair stated that Resident Council did not participate in the development of the questions in the survey.
This information was confirmed on the LTCH Licensee Confirmation Checklist completed on March 24, 2014 by the DOC. [s. 85. (3)]

2. The licensee did not ensure that the results of the survey were documented and made available to the Resident's Council.
(A) The Vice-Chair of Residents Council stated Council had not seen the results but they have been told the results are posted under glass on a bulletin board that is too high to be read from a wheelchair.
The DOC confirmed that the home posted the results of the survey on a bulletin board in the home on the LTCH Licensee Confirmation Checklist signed by the DOC and dated March 24, 2014. The bulletin board was observed the be under glass on a wall with a chair and table blocking access. The Environmental Manager agreed that the bulletin board would be very difficult or maybe impossible to read from a wheelchair.
[s. 85. (4) (a)]

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 68. (2)	CO #004	2013_191107_0009	156

Issued on this 1st day of May, 2014

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

BARBARA NAYKALYK-HUNT

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), IRENE PASEL (510), ROBIN MACKIE (511)

Inspection No. / No de l'inspection : 2014_214146_0006

Log No. / Registre no: H-000322-14

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

Report Date(s) / Date(s) du Rapport : Apr 28, 2014

Licensee / Titulaire de permis : 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

LTC Home / Foyer de SLD : LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Shelly Desgagne

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Grounds / Motifs :

1. Previously issued June 2011 as a VPC, August 2011 as a Compliance Order (CO), April 2013 as a VPC.
The licensee did not ensure that the following rights of residents were fully respected and promoted:
1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.
(A) In March 2014 resident # 034 was observed in the hallway, sitting in a chair, with body parts exposed. The PSW confirmed the exposure of the resident was inappropriate and was a violation of the resident's rights to dignity.
(B) In March 2014, during a meal service, two PSW's were observed to be sitting at the residents' dining tables engaged in personal conversations that did not include resident interaction. This was supported through a Resident Council interview which identified staff as frequently having personal conversations that excluded the residents, during meal service. In April 2014, during the provision

of resident care by two PSW's, the PSW's were observed to be engaged in a conversation of a personal nature, excluding the resident and using profanity. Interview with the ADOC confirmed participating in personal conversations during the provision of resident care does not recognize the resident's individuality nor respects the resident's dignity and is not the expectation of the home. (511)

2. The licensee did not ensure that the following rights of residents were fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
(C) In March 2014, dried food residue was observed on resident #080's face several hours after a meal service. In March 2014 food was observed on resident #110's face several hours after a meal service. In March 2014 at resident #071 was observed sitting in a chair in the hallway with dried food on the resident's face and clothing several hours after a meal service.
(D) In an interview in March 2014, the family of resident #080 reported an incident that the family had witnessed on an unspecified date in March 2014. The family rang the resident's call bell because the resident had expressed the need to be taken to the bathroom. The call bell was answered 15 minutes later by a staff member who, according to the family member, denied the request and told the resident it was too close to lunch and the resident had to go to the dining room. The resident's care plan indicated that constipation was a problem focus. The resident's right to be cared for in a manner consistent with his or her needs was not respected. There was no indication on the health record of the incident but a registered staff member stated he/she had vague recollection of hearing about the incident previously.
(146)

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0009, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated.

Grounds / Motifs :

1. Previously issued August 2013 as a CO.
As confirmed with the FSM on April 1, 2014,
(A) Resident #201's weights recorded in Point Click Care (PCC) computer system indicated an 8.5% weight change over three months. A dietary referral was sent by nursing to dietary in December 2013. The dietary referral was not completed; the resident's weight change was not assessed, and actions and outcomes were not evaluated.
(B) Resident #202's weights recorded in PCC in January and February 2014 indicated a change of 11.5% over one month, a 13.1% over three months and a 13.1% over six months . A dietary referral for the weight changes was not initiated. The resident's weight change was not assessed, and actions and outcomes were not evaluated. (156)

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

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_122156_0034, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that, 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 shall ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, specifically, the home's policy related to: bowel management and constipation; documentation; and hypoglycemia.

Grounds / Motifs :

1. Previously issued March 2014 as a Compliance Order (CO), July 2011 as a CO, October 2011 as a WN, April 2012 as a VPC, December 2012 as a CO, January 2013 as a CO and November 2013 as a CO.
The licensee of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was (b) complied with.
(A) The "Continence Bowel – Prevention of Constipation Home Specific Procedure, V3-240.1, dated August 16, 2013", was not followed. The policy required Registered staff to give 125 ml of prune juice if a resident had not had a bowel movement for three days, to administer 30 ml of Milk of Magnesia (MOM) if no bowel movement for three days, along with a referral to the RD for constipation and physiotherapy for mobility, a Dulcolax suppository if no bowel movement for four days and a fleet enema if no movement for five days, along

with notification to the MD.
(i) Resident #053 had experienced constipation and did not receive medications as prescribed by the physician on a date in March 2014.
(ii) Resident #053 had a bowel movement on a date in March 2014, and not again until four days later. A review of the progress notes and eMAR identified that the policy for prevention of constipation was not followed.
(iii) The same resident did not have a bowel movement for five days later in March. A review of the progress notes and eMAR identified that the policy for prevention of constipation was not followed
(iv) Resident #071 had experienced constipation in March 2014 on three separate occasions and did not receive medications as prescribed by the physician.

(B) The "Documentation Standards", V3-570, dated April 2013 policy was not followed. The policy required that documentation related to each event, action, or assessment must: document precisely, accurately, clearly and concisely.
(i) A review of the clinical record for resident #026 indicated that the resident received 125ml prune juice on three dates in March 2014, however, according to the eMAR, the resident did not receive prune juice on those dates. The registered staff confirmed that the documentation was not accurate.
(ii) In March 2014 meal service was observed and it was noted that resident #204 did not consume any of the lunch meal. Documentation, however, indicated on the intake flow-sheet and "look back report" that the resident had consumed 76-100% of the meal. Interview with the staff who completed the documentation confirmed that the staff did not actually observe the resident's intake and had asked another staff and therefore, could not verify the accuracy of the documentation.
This inspection did not include a follow up inspection related to the previous order for not complying with the home's hypoglycemia policy because no episodes of hypoglycemia had occurred since the previous order, therefore, it remains outstanding.

(156)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Issued on this 28th day of April, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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