Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 14, 2016;	2015_324567_0016 (A1)	032724-15	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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

BARBARA PARISOTTO (558) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

A change was made with respect to the compliance due date for CO#1 (related to safe transfers). The date was changed from April 29, 2016 to June 30, 2016.

Issued on this 3 day of May 2016 (A1)

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

Original report signed by the inspector.

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

BARBARA PARISOTTO (558) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 30, December 1, 2, 3, 4, 7, 8, 9, 10, 11, 15, 16, 17, 18, 2015.

The following intakes were completed concurrently with the RQI: Log no. 031575 -15 and 030201-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, Registered Dietitian, Director of Dietary Services, Director of Environmental Services, Resident Assessment Instrument (RAI) Coordinator, housekeeping and laundry staff, Substitute Decision Makers (SDMs), family members, registered staff, personal support workers, President of Resident Council and Representative of Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions; provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Resident and Family Council meetings, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Safe and Secure Home

Skin and Wound Care

Trust Accounts

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The home has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of a ministry report and progress notes revealed that on an identified date in 2015, resident #014 suffered a fall during a transfer while being provided care.

Review of records for resident #014 revealed that on an identified date in 2015, the resident was reassessed by physiotherapy and was found to need an assistive device for transfers as a result of his/her deteriorating condition as the resident.

Review of the resident’s written plan of care revealed that changes were made to the plan on an identified date in 2015, following the physiotherapy assessment, with respect to transfers. Record review of the resident’s written plan of care revealed that not all parts of the resident's written plan of care were updated to reflect the assessment.

Interview with RPN #135 revealed that not changing all parts of the written plan of care was an error on his/her part.

Review of the progress notes, investigation notes and interview with PSW #142 indicated that on an identified date in 2015, the resident was being transferred using an assistive device. During this transfer, the PSW indicated that he/she had not fully followed the manufacturer's instructions for use of the assistive device. The PSW stated that while using the assistive device, the resident sustained a fall. The resident was assessed by registered staff #143 and #144 and was found to have altered status and the resident didn't complain of significant pain. The resident was transferred later in the day to hospital related to pain and bruising and was found to have a fracture. The resident returned to the home on an identified date in 2015. On the day following the resident's return to the home, the resident exhibited worsened status and was transferred back to the hospital. The resident passed away shortly thereafter.

Interview with PSW #142 confirmed he/she had used an identified assistive device for some of the resident's transfers. When asked by the inspector if he/she had ever inquired as to why this was the case, the PSW responded he/she was just following the plan of care.

Interview with PSW #145 revealed that the resident had returned from the hospital prior to this incident and that he/she was very fragile and had been using an identified assistive device. PSW #145 stated that "some residents can't use certain assistive devices and you could see that if you used your head". She also stated that "looking at the resident, you wouldn't put her in the identified assistive device" and that "if they used the proper equipment, maybe she would be here, maybe she wouldn't".

Interview with ADOC #106 confirmed the home’s practice is that all PSWs are to use good judgment during every transfer and that PSW #142 showed poor judgment in

using a standing lift because of the resident's health condition. The ADOC also stated that despite this intervention being in the resident's written plan of care, PSW #142 should have asked why she was using an identified assistive device to transfer this resident in some instances and a different assistive device in others. The ADOC also stated she felt that the PSW showed no remorse related to her actions or the outcome. [s. 36.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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

Specifically failed to comply with the following:

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of a ministry report, submitted on an identified date in 2015, indicated that resident #020 was sent to the hospital on an identified date in 2015, related to particular health concerns but also had been diagnosed with a fracture to another specified part of his/her body, of which the home had not been aware.

Record review of progress notes for an identified date in 2015, revealed that PSW #139 reported to RPN #120 that resident #020 suffered a fall while being provided

care. The home's investigation notes also revealed PSW #139 was not able to safely assist the resident and as a result, the resident suffered the fall.

Review of a physiotherapy assessment conducted on an identified date in 2015, indicated that resident #020 was at an increased risk of falls related to his/her health condition. Further review of the progress notes revealed resident #020 had a fall on a previous occasion on an identified date in 2015. Post fall physiotherapy assessment revealed the resident complained of pain following this incident in the same part of his/her body that was later discovered to be fractured and that the plan was to monitor the resident closely.

Interview with PSW #139 revealed that on an identified date in 2015, while he/she assisted the resident, the resident exhibited identified behaviours and as a result suffered a fall.

Interview with an identified family member confirmed they had notified the home on admission that the resident exhibits identified behaviours in the course of specified activities. Further, the family member stated that the home had promised to take the above mentioned behaviour into consideration, but that they had not done so.

PSW #139 confirmed these falls had happened a specified number of times over a specified number of months as a result of the resident exhibiting these behaviours during the course of care. The PSW confirmed he/she had not communicated this information to the team, as he/she assumed they all knew about the resident's behaviour.

Interview with RPN #120 confirmed the resident needed assistance with specified activities by one staff, but was not aware the resident had previously experienced similar incidents. RPN #120 confirmed that because he/she was not aware of these incidents, he/she had not referred the resident to the physiotherapist to further assess the resident's ability. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident is given an opportunity to participate fully in the development of the plan of care.

Review of resident #006's progress notes revealed the RD completed a nutritional assessment on an identified date in 2015, and due to the resident's health status, ordered a supplement. A progress note on an identified date in 2015, revealed the resident was refusing the supplement.

Interview with the resident revealed he/she did not want the supplement.

Interview with the RD revealed he/she did not consult with resident #006 about whether he/she would like a supplement.

Interview with the interim DOC and the ADOC #106 confirmed that resident #006 was not provided the opportunity to participate fully in the development of the plan of care. [s. 6. (5)]

3. Interview with resident #005 revealed he/she would like to have a shower more often and would like to have a bath sometimes. The resident stated no one has ever asked him/her.

Interview with ADOC #106 and the interim DOC revealed that showering and bathing was an area the nursing department was working on because it had been identified that residents had not had the opportunity to participate in their shower/bath routine since admission. The home plans to conduct a survey in 2016 asking residents about their preference for bath or shower, timing of the bath or shower and the possibility of receiving more than two per week.

The interim DOC confirmed that currently residents had not been given the opportunity to participate in this part of their plan of care since their admission. [s. 6. (5)]

4. Interview with resident #007 revealed he/she would like to have his/her showers on days when it is not so busy for the nursing staff. The resident stated no one has ever asked him/her if he/she is happy with the showering routine.

Interview with PSW #132 revealed that on one of resident #007's shower days, there are more residents to shower.

Interview with ADOC #106 and the interim DOC revealed that showering and bathing is an area the nursing department is working on because it had been identified that residents had not been given an opportunity to participate fully in this plan of care. [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of resident #009’s assessment, conducted on an identified date in 2015, indicated the resident had altered skin integrity on an identified part of his/her body and that he/she was to use specified assistive devices as part of his/her treatment.

Review of the written plan of care revised on an identified date in 2015, revealed the resident had altered skin integrity on a specified part of his/her body. The plan for treatment was to follow the plan of care following the assessment.

Interview with RN #101 indicated the resident had very sensitive and fragile skin on the affected area.

Observation on an identified date in 2015, revealed resident #009 did not have the recommended treatment devices in place.

Interview with RN #101 and PSW #104 confirmed the resident did not have the assistive devices in place.

Interview with RN #101 confirmed that staff did not provide care to resident #009 as specified in the written plan of care to promote the healing of the wound.

Interview with the interim DOC confirmed the home's expectation is that staff is to provide care as indicated in the resident's written plan of care. [s. 6. (7)]

6. The licensee has failed to 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 the resident’s care needs change or care set out in the plan of care is no longer necessary.

Review of records, including progress notes and the written plan of care for resident #005 revealed that the resident had an identified medical condition. The resident was sent to hospital on an identified date and returned with an altered health condition.

Review of the written plan of care included that the resident used specified assistive devices and identified associated monitoring requirements.

Interview with PSW #140 and RN #141 confirmed that following the resident’s return from the hospital, the resident no longer required one of the identified assistive devices as a result of the resident's health condition.

Interview with the interim DOC confirmed that the written plan of care had not been updated to reflect the resident's care needs following return from hospital on an identified date in 2015. [s. 6. (10) (b)]

7. Review of resident #014's records revealed that on an identified date in 2012, the resident was assessed as needing the use of an assistive device for transfers. Review of records for resident #014 revealed that on an identified date in 2015, the resident was reassessed by physiotherapy and was found to need a different assistive device for transfers as a result of his/her deteriorating condition.

Review of the resident's written care plan revealed that changes were made to the written plan of care on an identified date in 2015, with respect to certain care requirements involving the use of the assistive device.

Interview with RPN #135 revealed that not changing the transfer method for all parts of the resident's plan of care was an error on his/her part.

The resident suffered a fall on an identified date in 2015. The written plan of care was not revised to reflect the change in assistive device until after the resident had fallen.

Interview with ADOC #106 confirmed that all parts of the written plan of care should have been updated to reflect the physiotherapist's assessment. [s. 6. (10) (b)]

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 LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 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:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 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:
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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully respects the resident's dignity is fully respected and promoted.

On an identified date in 2015, observation in the third floor hallway revealed PSW #125 speaking in a loud voice while going in and out of resident #006's room. The PSW stated three times "he/she had a loose bowel movement". Interview with the PSW revealed he/she needed to communicate this information to the RPN who was administering medication. The PSW admitted that he/she did not have to speak so loudly about a resident's private health condition. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity is fully respected and promoted.

On December 8, 2015, resident #012 was observed wearing one white and one black coloured sock.

Interview with the resident revealed he/she was not aware what colour socks he/she was wearing.

Interview with PSW #114 revealed there were no other socks in the drawer for the resident to put on, so he/she had to use non-matching socks. While the PSW was being interviewed, the inspector looked in the resident's drawer and found the resident had at least 10 pairs of matching socks folded and ready to use when PSW #114 was dressing him/her.

Interview with PSW #114 confirmed he/she did not look in the drawer for a pair of matching socks in the morning when she was dressing the resident.

The interim DOC confirmed PSWs are expected to check the resident's drawers and cupboards and dress the resident appropriately. Dressing a resident in mismatched socks does not respect the resident's right to be treated with respect and dignity. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity is fully respected and promoted.

On December 8, 2015, in room 512, while passing by the resident's washroom, inspector #600
detected a strong smell of urine. Observation of the resident's washroom revealed one plastic bag,three quarters full of soiled incontinence products and a hamper also three quarters full, containing soiled, wet linens.

Interview with PSW #114 revealed he/she keeps his/her cart with soiled incontinence products and linens in the residents' washroom, and disposes of them at the end of the shift. Further, she stated she does this because there is no other place where he/she can keep the cart.

Interview with RPN #109 confirmed staff is not to keep soiled linen and incontinence products in residents' washrooms. After they do their rounds and complete residents' care, they are expected to dispose of the used linens and soiled clothing in the laundry chute and dispose of soiled incontinence products in a place especially provided for that purpose.

Interview with the interim DOC confirmed staff are expected to respect the residents' rooms as their home and PSW's carts of soiled linen should not be kept in residents washrooms. As well, the interim DOC confirmed storing soiled incontinence products and linens this way does not promote the resident's right to be treated with respect and dignity. [s. 3. (1) 1.]

4. The licensee has failed to ensure that the resident's right to live in a clean environment is fully respected and promoted.

Observation and interviews revealed that the home was without the essential service of water on December 10, 2015, from approximately 1115 until 1700 hours. Interview with the Administrator and the Director of Environmental Services revealed that jugs of water were sent to each of the floors to enable the flushing of toilets.

On the same day at approximately 1450 hours it was observed the toilets in several specified rooms had not been flushed and were full of feces. Interview with ADOC #123 revealed that staff were not aware that the jugs of water were for flushing as they thought it was for drinking. Interview with RN #124 was aware that the jugs of water were for flushing the toilets with feces and could not explain why they had not been flushed. Interview with the Administrator revealed that staff may not have been flushing the toilets due to miscommunication or insubordination.

Interview with residents #002 and #040 on December 11, 2015, revealed they were glad the water was back because yesterday (December 10, 2015) the toilets were so backed up with feces that it was "disgusting" and "filthy". According to resident #002, no one from the home explained to them what was going on.

Interview with the Administrator confirmed the home could have done more to ensure the cleanliness of the toilets during this loss of water from the city and had not fully respected and promoted the residents' right to live in a clean environment. [s. 3. (1) 5.]

5. The licensee has failed to ensure that the residents' right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted.

On December 9, 2015, observation revealed PSWs #115 and #116 were not wearing name tags. Interview with the PSWs indicated they had forgotten their name tags at home. On December 15, 2015, observation revealed PSW #132 was not wearing a name tag. The PSW stated he/she is allergic to the metal backing of the tag and stated he/she was aware that it is the residents' right to know who is providing care. Observation on December 18, 2015, revealed PSW #116 was again not wearing a name tag and stated he/she forgot it at home.

On December 16, 2015, observation revealed PSW #115 was again not wearing a name tag. Interview with PSW #115 revealed the name tag has given him/her chest pains. Interview with the Administrator revealed that the home requires a physician's note if a staff member is unable to wear the name tag and the home has not received any such notes. In the meantime if staff are unable to tolerate the metal name tag, the old plastic name tag is to be used.

Interview with the interim DOC and Administrator confirmed that the home has not ensured that the residents' right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted. [s. 3. (1) 7.]

6. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to 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.

On December 11, 2015, the inspector observed that the computer screen was not

locked when the RN stepped away from the medication cart and went into the dining room to address a resident concern. Resident #021's personal health information(PHI) including his/her picture, name, room and bed number, and and list of ordered medications were visible to anyone in the main hallway and the inspector noted there were visitors to the home in the area.

Interview with RN #111 confirmed that he/she did not lock the screen after stepping away from the medication cart, as was expected by the home when the electronic Medication Administration Record (eMAR) was no longer in use.

Interview with the DOC confirmed that staff must protect the residents' PHI by logging out of the resident's eMAR when they finish administering medication. [s. 3. (1) 11. iv.]

7. The licensee has failed to ensure that the resident's right to meet privately with another person in a room that assures privacy is fully respected and promoted.

Interviews with resident #001 revealed that he/she does not have a private place to meet with visitors. He/she stated they can go to the dining room but that is not really private and is not aware of a private place in the building that they could go to. Observation revealed the resident is in a room with three other residents.

Interview with the ADOC confirmed there is no place in the home that residents can go to meet privately with visitors unless the resident makes a request, in which case a special office can be arranged. The home does not make it known to residents that this is an option. [s. 3. (1) 21.]

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 resident's right to be treated with courtesy and respect and in a way that fully respects the resident's dignity is fully respected and promoted
-to ensure that the resident's right to live in a clean environment is fully respected and promoted
-to ensure that the residents' right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted
-to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to 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
-to ensure that the resident's right to meet privately with another person in a room that assures privacy is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways must be kept closed and locked.

On December 2, 2015, at 1030 and 1100 hours the inspector observed that the south stairwell door on the first floor was not locked. At approximately 1110 hours the interim Director of Care (DOC) and the inspector observed a visitor coming out of the first floor stairwell and the door did not close and lock behind him/her. It was further observed by the inspector and the interim DOC that when the second and sixth floor stairwell doors were opened the doors did not swing closed and lock. It was noted that the doors needed to be pulled shut in order for them to be locked. There was no evidence of an alarm being activated when these doors were not locked. There was signage by the doors that stated "please check that the door is closed behind you." These doors were located by a resident dining area on the first floor and by resident rooms on the second to sixth floors where residents had been observed to ambulate frequently. These doors were observed to be locking later in the day on December 2, 2015, and were not observed to be unlocked again throughout the inspection.

Interview with the Administrator confirmed these doors should be kept closed and locked. [s. 9. (1) 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 all doors leading to stairways must be kept closed and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's furnishings are maintained in a good state of repair.

Throughout the inspection, observations revealed many chairs and stools were ripped, exposing foam padding, including:
• Ripped folding chair in room 216
• Two chairs at the nursing station on second floor
• Three chairs at nursing station on fourth floor
• Four stools in the fourth floor dining room

Interview with the Director of Environmental Services and ADOC #106 confirmed these chairs and stools were not in a good state of repair and could promote the spread of infection because they could not be properly cleaned. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed by residents.

On December 11, 2015, while in the hallway, the inspector heard resident #042 making a statement regarding her health condition. When the inspector entered the room, it was observed that the resident's call bell cord was on the floor. The inspector gave the resident the call bell cord and the resident was able to pull the cord. PSWs came to the room and tended to the resident. Interview with PSW #130 revealed that the resident's call bell cord should be within reach and clipped to the bed sheets.

On December 16, 2015, the inspector observed resident #043 in bed and calling "nurse?". The inspector observed that the resident's call bell cord was on his/her dresser and not accessible to the resident. The inspector gave the cord to the resident who pulled it. Interview with PSW #134 revealed he/she forgot to clip the cord to the resident's bed but knew the call bell should be accessible to the resident at all times.

On December 18, 2015, while in the hallway, the inspector heard resident #042 again calling out. When the inspector entered the room the call bell cord was observed wrapped around the lower rail of the bed rail. Interview with PSW #116 revealed this cord is unreachable by the resident and the PSW admitted he/she had not noticed this before.

Interview with the interim DOC and Administrator confirmed that call bell cords should be accessible to residents at all times. [s. 17. (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 to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed by residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment for the resident whenever there is a significant change in the resident's health condition.

Record review revealed resident #006 had significant weight changes.

Progress notes revealed an RD assessed the weight change on an identified date in 2015, and because the resident was in the hospital at the time, recommended that nutritional status be re-evaluated upon return. Progress notes revealed the resident returned a few days later, and nursing sent a referral to the RD the same day, for a change in condition and poor intake. Another referral was sent several weeks later for a new health condition related to altered skin integrity. Another referral was sent a few days later, related to another health condition. Record review and interview with the RD revealed he/she did not assess the resident until a few weeks following the last referral.

Interview with the RD revealed that he/she would have liked to have assessed the resident sooner but due to time constraints could not. Interview with the interim DOC and ADOC confirmed that a nutritional assessment for resident #006 should have been completed soon after the resident returned from the hospital due to significant changes in her/his health condition. [s. 26. (4) (a),s. 26. (4) (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 the registered dietitian who is a member of the staff of the home completes a nutritional assessment for the resident whenever there was a significant change in the resident's health condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of a ministry report submitted on an identified date in 2015, indicated resident #020 had been sent to hospital related to a health condition. An X-ray done in the hospital had identified a fracture to a specified part of the resident's body, of which the home had not been aware.

Review of resident #020's progress notes revealed the only incident that could have coincided with the fracture was a fall that took place on an identified date in 2015, where PSW #139 reported to RPN #120, that the resident had fallen as a result of identified resident behaviours and the PSW could not help the resident safely.

Review of resident #020’s assessment record indicated a post-fall assessment had not been conducted to assess the resident after the fall using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with RPN #120 confirmed he/she did not conduct a post fall assessment using a clinically appropriate assessment instrument because he/she had not considered the incident to be a fall.

Interview with the interim DOC confirmed that when a resident has a fall or there is some indication the resident had a fall, staff are expected to assess the resident using a clinically appropriate post fall assessment tool specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: 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,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Record review revealed resident #006 had altered skin integrity. The resident was referred to the Enterostomal Nurse and an identified device was recommended as part of the treatment plan.

Review of the progress notes and interview with RPN #102 confirmed the home did not have the identified device for resident #006 at that time.

Review of resident #009's assessment, conducted on an identified date in 2015, indicated the resident had altered skin integrity and identified devices were ordered as part of his/her treatment. Observation of the resident throughout the inspection revealed the resident did not have the ordered devices.

Interview with RN #101 confirmed they did not have the identified devices for resident #009's altered skin integrity.

Interview with RN #111 confirmed he/she did not have enough supplies on the weekend of October 5 and 6, 2015, so he/she had to use surplus supplies to provide the ordered treatment to the residents.

Interview with RPN #131 revealed that resident #024 had altered skin integrity on identified parts of his/her body. Further, RPN #131 confirmed there were not enough supplies for him/her to provide the required care to resident #024's as per his/her treatment so the nurse borrowed from surplus supplies from another resident with the same treatment.

Interview with RN #117 confirmed they are often short of dressing supplies specifically ordered for individual residents. The staff use whatever supplies they have in the medication room until the prescribed supplies are provided. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #10: 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 remain in the original labelled package provided by the pharmacy service provider until administered to a resident.

On December 10, 2015, at approximately 1630 hours, on the fourth floor, north side, the inspector observed one plastic medication cup containing half a pink tablet and one plastic cup containing a white and red capsule.

Interview with RN #122 confirmed these two medications were controlled substances and that he/she had removed the medications out of the blister packages they came in, so he/she could give them to the residents at 2000 hours.

Record review of the electronic Medication Administration Record (eMAR) for resident #022 revealed the resident was prescribed a specified medication to be given, by mouth, at bedtime.

Review of resident #023's eMAR revealed an order for a specified medication to be given one capsule by mouth at bed time.

The RN confirmed the home expects staff to keep medications in their original pouches until they are administered to the residents. He/she also added that most staff take the medications out of the packages immediately before they are administered.

Interview with the interim DOC confirmed the expectation is that medication is to remain in its original package until it is administered to the resident. [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 package provided by the pharmacy service provider until administered to a resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident.

Interviews with residents #002, #005 and #007 revealed they had concerns regarding their showering routines. Record review revealed that these residents had not had a care conference in 2014 or 2015.

Interview with ADOC #106 confirmed there was no evidence that these annual conferences had taken place. [s. 27. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review of resident #006's written plan of care revealed the resident was at high risk for altered skin integrity due to his/her health condition. He/she had a history of altered skin integrity and required extensive assistance related to this. The plan set out in resident #006's written plan of care indicated that staff are to ensure the resident is provided an identified intervention as per a pre-determined schedule to ensure compliance with treatment.

Interview with PSW #103 indicated the PSWs provide the intervention as per the schedule or more often if required. The PSW confirmed they do not document the intervention.

Interview with RN #101 and RPNs #102 and #109 confirmed staff do not document the required intervention because they don't know how to set it up in the computer.

Interview with the interim DOC confirmed staff are expected to document every intervention they provide and any time after the intervention is provided. [s. 30. (2)]

WN #13: 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 has failed to ensure that each resident of the home is bathed by the method of his or her choice, including tub baths.

Interview with resident #002 revealed he/she would like to have a bath instead of a shower sometimes because he/she used to have baths at home. The resident stated that the tubs at the home were not working.

Interview with ADOC #106 and the interim DOC revealed this is an area the nursing department is working on because it had been identified that bathtubs had not been used and baths offered because the PSWs had found it easier and faster to give showers. The DOC confirmed that the home had not ensured that residents are bathed by the method of their choice, including tub baths. [s. 33. (1)]

WN #14: 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. Every licensee of a long term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

Interview with PSW #100 revealed the resident often refused care of his/her fingernails. The PSW stated that the policy in the home is for PSWs to report such refusals to registered staff and PSWs are to document the refusal. PSW #100 stated he/she had reported resident #043's refusal but could not recall who he/she reported this to and could not find his/her documentation regarding any refusal.

Review of resident #043's progress notes for a specified interval of time in 2015, revealed no notes regarding refusals of care.

Review of the home's policy #VII-G-10.50, titled, "Hygiene, Personal Care & Grooming" revised January 2015, indicated that PSWs are to clean residents' fingernails daily. Interview with ADOC #106 and the interim DOC confirmed that if a resident refuses care, it should be reported and documented.

ADOC #106 confirmed that the resident had not received fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs include the implementation of policies and procedures relating to nutrition care.

Review of the home's policy #VII-G-20.80, titled, "Monitoring of Resident Weights" revised January 2015, indicated that all residents will be weighed monthly and if there is a two kilogram (kg) difference, the RN will ask the PSW to reweigh the resident.

Review of resident #009's weight record revealed a weight loss of an identified number of kilograms for a specified time interval in 2015 representing a difference of greater than two kilograms. Interview with RN #101 revealed he/she did not notice this weight change and did not ask for a reweigh. Review of the resident's weight record and progress notes and interview with the RD revealed a reweigh was requested but did not take place.

Interview with the interim DOC and ADOC #106 confirmed that the home was not following their policy to reweigh residents with a weight loss or gain of two kilograms or greater.

Review of resident #006's weight record revealed there were no weights entered for identified months in 2015, and there was no indication in the progress notes that he/she had refused.

Interview with RPN #102 and the RD revealed that if a resident refuses to be weighed, it should be documented as such.

Interview with the interim DOC and the ADOC #106 confirmed that the home was not following their policy to weigh residents monthly or document their refusals. [s. 68. (2) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meal service is provided in a congregate dining setting unless a resident's assessed needs indicate otherwise.

On a specified date in 2015, observation on the second floor revealed resident #041 eating lunch outside the dining room by the nursing station. Interview with Dietary Service Supervisor #129 revealed residents eating outside the dining room usually need more supervision and/or have behaviours that are not suitable for pleasurable dining. He/she further stated that these residents have been assessed and it is part of their plan of care.

Review of resident #041's medical record revealed there had been no assessment that the resident needs to eat outside the dining room and it is not part of his/her plan of care. Interview with RN #126 revealed that for this resident, there had not been an assessment that indicated resident #041 needed to eat outside the dining room.

Interview with the Dietary Services Supervisor and Director of Dietary Services confirmed that for all residents eating outside the dining room, there needs to be an assessment. [s. 73. (1) 3.]

WN #17: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping of the Act, that procedures are developed and implemented for cleaning and disinfection of the following in accordance with the manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On December 15, 2015, the inspector observed resident #026 walking in front of the nursing station using an assistive device. The device was dirty, with some particles of old dry food on the top.

Interview with RN #111 revealed that staff clean the assistive devices every night and follow a schedule. According to the schedule this resident's device was to be cleaned on the day the resident had a bath.

Review of the wheelchair cleaning schedule revealed staff had not signed off the cleaning of resident #025's assistive device.

Interview with RN #111 further revealed he/she had left a note for the night staff on December 10, 2015, to clean resident #025's device, but night staff reported back to the RN they did not have a brush or solution for some time to clean the devices. The RN confirmed he/she had communicated this to management prior to December 10, 2015, but the supplies had not arrived.

The RN also confirmed the resident's device had not been cleaned according to the schedule. [s. 87. (2) (b)]

2. Observation of resident #008 on December 9, 2015, at approximately 1100 hours revealed that the headrest on his/her wheelchair was stained.

Review of the third floor cleaning schedule binder revealed that the resident's wheelchair cleaning had not been signed off by staff.

Observations and interview with ADOC #106 confirmed that the resident's wheelchair did not appear clean and that staff were not signing to indicate they had cleaned the wheelchairs. [s. 87. (2) (b)]

WN #18: 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,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

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 has failed to ensure that the residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Interview with resident #002 revealed the resident had bought a specified number of clothing items on an identified date in 2015, and had taken them to the laundry to be labelled. The staff in the laundry had told the resident the labeling machine was broken so they would label the clothing with a marker. The resident left the clothing in the laundry and according to the resident, the items of clothing were never returned to him/her.

Interview with RN #111 confirmed the resident had bought sweaters and pants and

had taken them down to the laundry. At that time, the labeling machine was broken and the laundry staff used a regular marker to label the resident's clothing but the marker would just wash off. The RN brought that to the attention of the laundry staff.

Interview with the Director of the Environmental Services confirmed that for some time the home did not have a labeling machine to label the clothing. During this time, some of the clothing had been lost because they weren't properly labeled. [s. 89. (1) (a) (ii)]

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

Interview with PSWs #113 and #112 revealed that on numerous occasions there was not enough linen, including towels, wash cloths and soaker pads to provide proper care to the residents. PSW #113 indicated that each of the six PSWs:
-on December 7, 2015, received three towels, no soaker pads and three face cloths,
-on December 8, 2015, they received three towels, one face cloth, one soaker pad,
-and on December 9, 2015, they received four towels, three face cloths, one soaker pad for each of their 10 residents.

Interview with residents #007, #002 and #004 indicated that many times they didn't have either towels or face-cloths to wash themselves.

Interview with RN #111, #128 and RPN #131 confirmed staff had complained of not having enough towels, face cloths or soaker pads. They further confirmed that this issue had been brought to management's attention.

Interview with the Director of Environmental Services confirmed the home is low on the above-mentioned linen and they were working on providing more linen to the staff. [s. 89. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance.

On December 1, 2015, observation revealed that the lighting at the entrance of an identified room was dark and two overhead lights were not working. On December 2, 2015, observation revealed that the lighting in an identified room was dark and a bulb was not working in the washroom light fixture and in the over the bed light fixture.

Interview and observation with the Director of Environmental Services (DES) on December 17, 2015, revealed these rooms were dark. The DES revealed that he/she had not received a maintenance request for these lighting issues and the lights in the resident rooms are not part of the home's daily maintenance checks. He/she revealed the home relies on housekeepers and nursing department staff to inform the maintenance department of issues in resident rooms and that there are no schedules in place for routine, preventive and remedial maintenance in every resident room. [s. 90. (1) (b)]

2. The licensee has failed to ensure that procedures are developed and implemented

to ensure that all equipment, devices, assistive aides and positioning aids in the home are kept in good repair.

On December 3, 2015, observation revealed a cracked commode chair in a shared washroom of an identified room. Observation and interview with ADOC #106 on December 17, 2015, confirmed that this assistive aide is not in a good state of repair and needed to be replaced immediately. The ADOC stated that devices in need of repair need to be reported by PSWs to the maintenance department through their online reporting system and redirected the PSW at this time. [s. 90. (2) (b)]

3. The licensee has failed to ensure that procedures are implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

On December 1, 2015, observation revealed that the toilet in an identified room was running long after being flushed. Inspector #567 brought this to the attention of nursing staff. On December 17, 2015, inspector #501 observed it was still running and according to the Director of Environmental Services (DES), this was not communicated to the maintenance department through their online system.

On December 1, 2015, observation revealed a cracked counter around the sink in the washroom of room #305. Observation and interview with the DES on December 17, 2015, revealed it was cracked and needed to be fixed or replaced. Interview with resident #002 revealed that the toilet in the washroom of room #305 sometimes leaked. Interview with the DES on December 17, 2015, confirmed that there needed to be caulking around the toilet to prevent this.

On December 1, 2015, observation revealed a corroded tap in the washroom of room #316. Observation and interview with the DES on December 17, 2015, revealed this tap needed to be replaced.

Interview with the DES confirmed that the home has not maintained plumbing fixtures, toilets and washroom fixtures and accessories. The DES stated that he/she needed to reinforce to all staff the need to report the above-mentioned maintenance issues. [s. 90. (2) (d)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, to inform the Director of the incident no later than three business days after the occurrence of the incident.

Review of a ministry report, submitted on an identified date in 2015, indicated resident #020 had been sent to the hospital on an identified date in 2015, and diagnosed with a fracture. The resident returned to the home on the same day and and was asked to return to the hospital on a future date for further investigation and treatment.

Interview with ADOC #106 confirmed the report was submitted late. The ADOC indicated the home is aware of when to report a critical incident to the Director, but they did not have enough information to submit the report. The ADOC confirmed the home could have contacted the Director to inform them of the incident and they could have submitted an update to the report once they had more information. [s. 107. (3.1) (b)]

WN #21: 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 has failed to ensure that 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.

Record review of the electronic Medication Administration Record (eMAR) for resident #022 revealed the resident was prescribed a specified medication to be given by mouth at bed time. Resident #023 was prescribed a specified medication to be given one capsule by mouth at bed time.

On December 10, 2015, at approximately 1630 hours, on an identified unit, the inspector observed one plastic medication cup containing half a pink tablet and one plastic cup containing a white and red capsule in the top drawer of the medication cart where staff kept their nursing supplies.

Interview with RN #122 revealed the half tablet was for resident #022 and the white and red capsule was for resident #023. The RN confirmed these two medications were controlled substances and he/she had removed the medications out of the blisters they came in, and out of the narcotics box so he/she could give them to the residents at 2000 hours. The RPN was not able to explain why he/she took the controlled medication out of the narcotic box. He/she confirmed that the home expected staff to keep the controlled substances in the narcotic box and double-locked.

Interview with the interim DOC confirmed the expectation is that controlled substances are to be kept in the narcotic box and to be double locked at all times. [s. 129. (1) (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On December 11, 2015, at breakfast time, on an identified unit in front of the dining room, the inspector observed resident #021 was administering the medication to him/herself as the RN was looking at his/her computer screen, not monitoring the resident. The resident self-administered the medication and returned it to the registered nurse.

Review of the doctor's orders revealed there was no doctor's order for the resident to self-administer the medication.

Review of the resident's chart and electronic documentation revealed no assessment record for this resident.

Interview with RN #119 revealed this resident did not have a doctor's order approving self-administration of medications. The RN indicated he/she will make sure the resident is assessed by the physician and an order provided as soon as the physician attended the floor. [s. 131. (5)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Throughout the inspection, observations revealed many used, unlabelled personal items in shared washrooms that included:
• On December 1, 2015, in room 216 there was an unlabelled used urine hat and used toothbrush.
• On the same day, in room 316 there were unlabelled used toothbrushes and comb in an unlabelled blue plastic cup.
• On December 2, 2015, in room 223 there were unlabelled used toothbrushes.
• On December 3, 2015, in room 323 there many used and unused urine hats, used unlabelled denture cups, old urine container with resident's name on it and an unlabelled toothbrush.
• On December 17, 2015, in room 515 there were unlabelled used toothbrushes, comb on the counter and urine hats on the floor on top of a raised toilet seat.

Interview with ADOC #106 confirmed that these items should be labelled or are of a disposable nature and should be thrown away in order to prevent the transmission of infectious diseases. [s. 229. (4)]

Issued on this 3 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de sions de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BARBARA PARISOTTO (558) - (A1)

Inspection No. / No de l'inspection : 2015_324567_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 032724-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Apr 14, 2016;(A1)

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 : Midland Gardens Care Community
130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sara Rooney

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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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare and submit a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who require lift with mechanical device.

The plan will include, at a minimum, the following elements:
-Education for all direct care staff, including:
*The types of lifts used in the home for transferring residents,
*A review of the criteria for the use of each,
*What to do when a lift is identified to be in a state of poor repair

-A review of the plans of care for those residents requiring the use of a mechanical lift to ensure that all plans are up to date and accurately convey which lift to use at all times
-A system to randomly audit resident transfer practices to ensure:
*practice is guided by residents care planned needs,
*proper transfer practice and use of lifts, according to manufacturer directions

For all the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each part of the plan.

Please submit the plan to Sofia.daSilva@ontario.ca no later than March 4, 2016.

Grounds / Motifs :

1. The scope of this finding is isolated to this resident, the severity is actual harm as the resident suffered a fracture and later died. There is no prior history related to this legislative reference.

The home has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of a ministry report and progress notes revealed that on an identified date in 2015, resident #014 suffered a fall during a transfer while being provided care.

Review of records for resident #014 revealed that on an identified date in 2015, the resident was reassessed by physiotherapy and was found to need an assistive device for transfers as a result of his/her deteriorating condition as the resident.

Review of the resident's written plan of care revealed that changes were made to the plan on an identified date in 2015, following the physiotherapy assessment, with respect to transfers. Record review of the resident's written plan of care revealed that not all parts of the resident's written plan of care were updated to reflect the assessment.

Interview with RPN #135 revealed that not changing all parts of the written plan of care was an error on his/her part.

Review of the progress notes, investigation notes and interview with PSW #142 indicated that on an identified date in 2015, the resident was being transferred using an assistive device. During this transfer, the PSW indicated that he/she had not fully followed the manufacturer's instructions for use of the assistive device. The PSW stated that while using the assistive device, the resident sustained a fall. The resident was assessed by registered staff #143 and #144 and was found to have altered status and the resident didn't complain of significant pain. The resident was transferred later in the day to hospital related to pain and bruising and was found to have a fracture. The resident returned to the home on an identified date in 2015. On the day following the resident's return to the home, the resident exhibited worsened status and was transferred back to the hospital. The resident passed away shortly thereafter.

Interview with PSW #142 confirmed he/she had used an identified assistive device for some of the resident's transfers. When asked by the inspector if he/she had ever inquired as to why this was the case, the PSW responded he/she was just following the plan of care.

Interview with PSW #145 revealed that the resident had returned from the hospital prior to this incident and that he/she was very fragile and had been using an identified assistive device. PSW #145 stated that "some residents can't use certain assistive devices and you could see that if you used your head". She also stated that "looking at the resident, you wouldn't put her in the identified assistive device" and that "if they used the proper equipment, maybe she would be here, maybe she wouldn't".

Interview with ADOC #106 confirmed the home's practice is that all PSWs are to use good judgment during every transfer and that PSW #142 showed poor judgment in using a standing lift because of the resident's health condition. The ADOC also stated that despite this intervention being in the resident's written plan of care, PSW #142 should have asked why she was using an identified assistive device to transfer this resident in some instances and a different assistive device in others. The ADOC also stated she felt that the PSW showed no remorse related to her actions or the outcome. (567)

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

Jun 30, 2016(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that the staff and others involved in the different aspects of care of resident #020 collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, related to transfers.

The plan will include, at a minimum, include the following:

-education that includes the definition of collaboration in assessment, including the importance of collaboration with residents, their families, and all other individuals that are involved in resident's care and well-being, to ensure safe transfers.

-a process to ensure all disciplines understand and practice collaboration. The process will include which staff are involved in collaboration, when they collaborate, and a plan for documentation, as it relates to resident transfers.

-a training schedule for the staff to roll out the new process and expectations

-development of a quality component to address the ongoing monitoring of this new process.

For all the above, as well as for any other elements included in the plan, please
include who will be responsible, as well as a timeline for achieving compliance,
for each part of the plan.

Please submit the plan to Gordana.Krstevska@ontario.ca no later than March 4, 2016.

Grounds / Motifs :

1. This order is being served on the home as a result of other findings of non-compliance during this RQI related to the safe transfer of residents.

The licensee has failed to ensure that staff and others involved in the different

aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of a ministry report, submitted on an identified date in 2015, indicated that resident #020 was sent to the hospital on an identified date in 2015, related to particular health concerns but also had been diagnosed with a fracture to another specified part of his/her body, of which the home had not been aware.

Record review of progress notes for an identified date in 2015, revealed that PSW #139 reported to RPN #120 that resident #020 suffered a fall while being provided care. The home's investigation notes also revealed PSW #139 was not able to safely assist the resident and as a result, the resident suffered the fall.

Review of a physiotherapy assessment conducted on an identified date in 2015, indicated that resident #020 was at an increased risk of falls related to his/her health condition. Further review of the progress notes revealed resident #020 had a fall on a previous occasion on an identified date in 2015. Post fall physiotherapy assessment revealed the resident complained of pain following this incident in the same part of his/her body that was later discovered to be fractured and that the plan was to monitor the resident closely.

Interview with PSW #139 revealed that on an identified date in 2015, while he/she assisted the resident, the resident exhibited identified behaviours and as a result suffered a fall.

Interview with an identified family member confirmed they had notified the home on admission that the resident exhibits identified behaviours in the course of specified activities. Further, the family member stated that the home had promised to take the above mentioned behaviour into consideration, but that they had not done so.

PSW #139 confirmed these falls had happened a specified number of times over a specified number of months as a result of the resident exhibiting these behaviours during the course of care. The PSW confirmed he/she had not communicated this information to the team, as he/she assumed they all knew about the resident's behaviour.

Interview with RPN #120 confirmed the resident needed assistance with specified activities by one staff, but was not aware the resident had previously experienced

similar incidents. RPN #120 confirmed that because he/she was not aware of these incidents, he/she had not referred the resident to the physiotherapist to further assess the resident's ability. (600)

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

Apr 29, 2016

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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 sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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

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 sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 3 day of May 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SOFIA DASILVA - (A1)

Service Area Office /
Bureau régional de services : Toronto